MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02021 physician and completely filled in by the funeral left please remove carbon papers. Pages 1 and 2 ovel, and in any event, within 72 hours after death. law requires that the deoth certificate be executed within 24 hours ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Carroll Maryland Frederick MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) Rural--Sykesville 8mo. Lidavs Brunswick d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital NO T 503 Sixth Avenue YES | 3. NAME OF First Middle 4. DATE Lost Day Year DECEASED (Type or print) 27 19 67 Delena Ambrose DEATH Pear] IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthday) Months Haurs Days white 1/15/85 female WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? West Virginia USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Samuel Bohrer Eliza Hoyle signed by the ottending buriol-transit permit. The 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service 214-54-0537 Springfield Hospital records, Sykesville, Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY ONSET AND DEATH Septicemia IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or ottending physician DUE TO Canditions, if any, which gave decubitus ulcers days rise to immediate couse (a) DUE TO stating the underlying cause as the TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)

Chronic brain syndrome associated with circulatory disturbance with psychotic reaction. 19. WAS AUTOPSY PERFORMED? for use Health p NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Jo detoched (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c. TIME OF INJURY Manth, Doy, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (State) Hour o.m. Nat While factory, street, office bldg., etc.) at wark at wark 21. I certify that * (this haspital) attended the deceased fram _, 1966__, ta. 2/27/, 19 67, that (1/2 (we) last should 2/27/ 1967, and that death accurred at 10:45M, from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE 2/27/67 K M.D. DIRECTOR PHYS. PHYS director, poge Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) N. Buyukunsal, M. D. Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (State) (County) REMOVAL (Specify) RUHSWICK 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Melianelas

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Division of STATISTICAL DESEABCH AND DECORDS 301 W PRESTON STREET RAITIMORE MARYLAND 21201

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			Middle	Arven	4. DATE Month OF DEATH Februar	v 10 19 67
S.	Male Whit			8. DATE OF BIRTH	9. AGE (In years last birthday)	Months Doys Hours Min.
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	Constantine .	Aventopolis		Olymp	ia	
15.	WAS DECEASED EVER IN U.S. ARM es, na, ar unknawn) (If yes give w	ED FORCES? 16		. INFORMANT	Addres	S
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MEDICAL	20c. TIME OF INJURY Manth, Hour a.m.			LACE OF INJURY (Hame, far actory, street, affice bldg., etc		(Caunty) (State)
	21. 1 certify that (1) saw the deceased or	(this haspital) atte	nded the deceased fram,	2/20/66 , nat death occurred o	19.66 to 2/10/67	7, 19_67, that (1) (we) last and on the date stated above
Я	22a. SIGNATURE					22b. DATE SIGNED
	K/ (or	mores		M.D. PHYS.	MED. STAFF DIRECTOR PHYS.	2/10/67
	22 PHYSICTAN'S			22d. ADDRESS		C)
	NAME (Type)	E. Conne			ield State Hosp	
230		b. DATE THEREOF	23c. NAME OF CEMETERY C		23d. LOCATION (City or Tow	rn) (Caunty) (Stote)
	REMOVAL (Specify) Burial	2/14/67	Mays Cha		Baltimpre	
	n. Cook-Brooks	Inc Balti	MORESS Md 2120			SISTRAR'S SIGNATURE
WI	". COOK-Prooks	Inc. Darci	more, Mu. 2120	DETER	16 1967	mage

VR A15 (4) 20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificote be executed within 24 hours ofter deoth.

Poge 4 moy be retained by the hospital or ottending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached far use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after deat

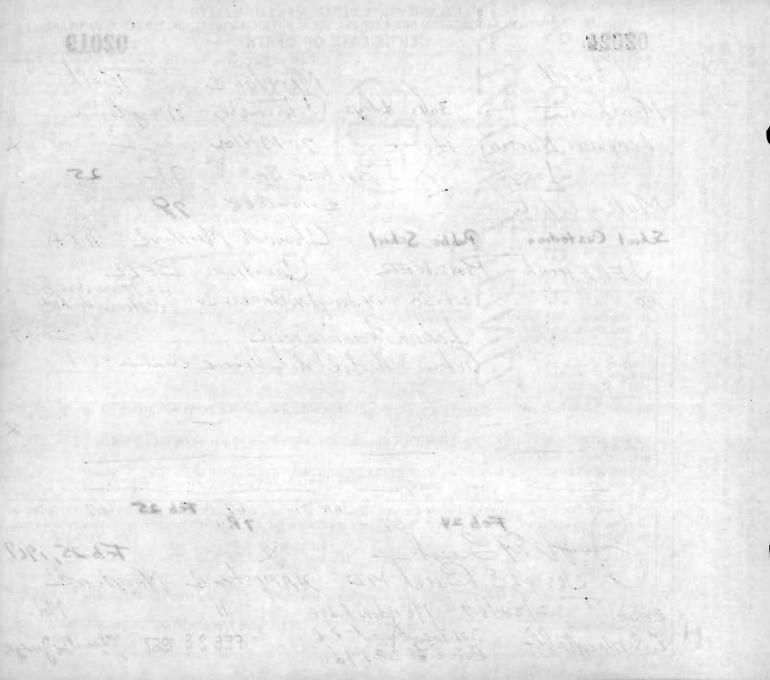
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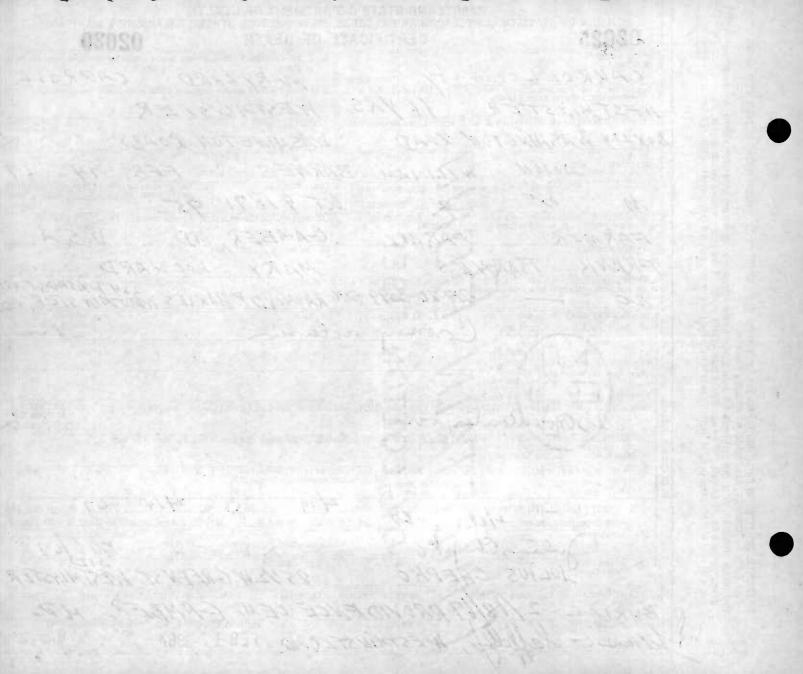
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY Pages I arrol after MARYLAND b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b IOWN (If outside corporate limits, write RURAL end give nearest town) you papers. Page write RURAL and give nearest town) hours = whook filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? NO YES etely hod 3. NAME OF Middie DATE Month Year DECEASED and comple remove carb r any event, DF DEATH (Type or print) 19 6 7 SEX 6. COLOR OR RACE 7. MARRIED AGE (In years | IF UNDER 1 YEAR NEVER MARRIED last birthday) Months ! Days Hours WIDOWED DIVORCED = 1Da. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) physician lease and ir during most of working life, even If retired) COUNTRY? Custodian death certificate ā 13. FATHER'S NAME MOTHER'S MAIDEN NAME hen 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT 1 Address loom sbury are the attenit 0 (Yes, no, or unknwn) \((\)(If yes give war or dates of service) transit perm cremation, NO INTERVAL BETWEEN CAUSE DF DEATH [Enter only one cause per line law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) al-trans the hospital or attending physician. 2-20-67 been street the burial, controlled to DUE TO Conditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating the underlying cause last. (c) as CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? The certificate NO X YES PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) detached for the detached for the Dept. of I OR CONTRIBUTING CLICAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) be de State factory, street, office bldg., etc.) Hour a.m. While Not While OR ATTENDING I p.m. at work at work P 21. Joestly that (1) (this hospital) attended the deceased from JAN 31-1967, to Feb 25, 1967, that (1) (we) last DIRECTOR: age 3 should lied with the and that death occurred at 7 P.M. from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22a. SIGNATURE 22b. page ATTENDING PHYS. MED. DIRECTOR Page 4 may 1 M.D. PHYSICIAN'S NAME (Type) FUNERAL 22d. ADDRESS director, p should be f BURIAL, CREMATION. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY. LOCATION (City, town or county) (State) 0 REMOVAL (Specify) Id FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE 20M 1/65



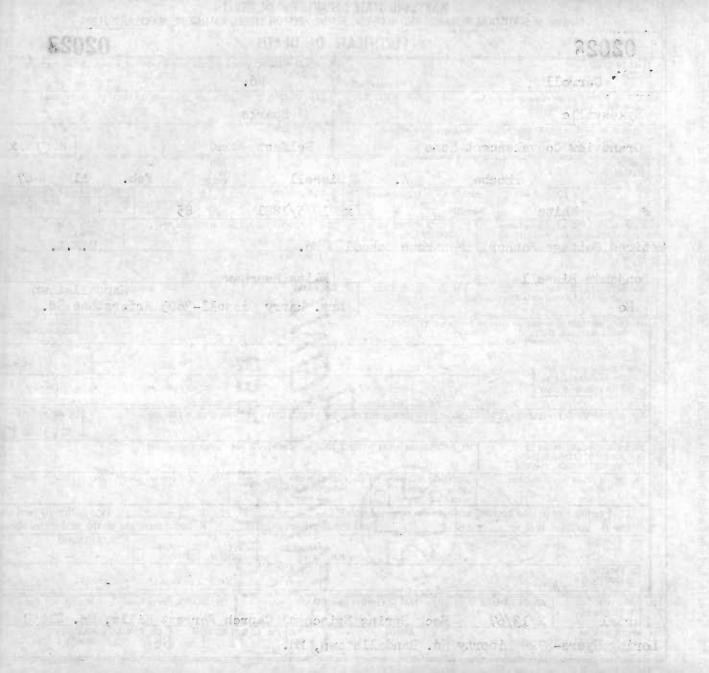
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Page in any event, within 72 hours and</td><td>8</td><td>ROX22Y WASHINGTON ROAD WASHINGTON ROAD</td><td>YES NO</td></tr><tr><th></th><th>within pletely garbon p nt, withi</th><th>3.</th><th>DECEASED OF TO I</th><th>1 1 -</th></tr><tr><th></th><th>d w mple car ent,</th><th>_</th><th>(Type or print) JOHN WILLIAM BAN(NES DEATH FEB, 19</th><th>19 6 /</th></tr><tr><th></th><th>and compressions of the compression of the compress</th><th>3.</th><th>last birthday) Months Days</th><th></th></tr><tr><th></th><th>exe rem nan</th><th>108</th><th>WIDOWED DIVORCED C. J. J.</th><th>N OF WHAT</th></tr><tr><th></th><th>icate be ey physician a n please re wal, and in</th><th>dur</th><th>ring most of working life, even If retired) INDUSTRY FAR 10 FR MD</th><th>RYZ</th></tr><tr><td></td><td>ohys al, a</td><td>13.</td><td>3. FATHER'S NAME 14. MOTHER'S MAIDEN WAME</td><td>day -</td></tr><tr><td></td><td>eath certificate be attending physician ermit. Then please on, or removal, and i</td><td></td><td>FRANK BARNES MARY LOCKARD</td><td>26-163</td></tr><tr><td></td><td>endi it.</td><td>15 (Ye</td><td></td><td>SHINGTONRY</td></tr><tr><td></td><td>death he atte permit tion, or</td><td></td><td>NO 219-20-3099 SON. RAYMOND P. BARNES WESTHIN.</td><td>SIEK, MO</td></tr><tr><td></td><td>he of the sit partition</td><td></td><td>The broad of beauty feature only one seaso by more to (a), and (a),</td><td>NSET AND DEATH</td></tr><tr><td></td><td>requires that the ding physician. been signed by the burial-transit or to burial, crema or to burial, crema</td><td></td><td>PART I. 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PHYSICIAN'S NAME (Type) 101 105 CHEPKO 22d. ADDRESS OF W. CREEN ST WEET</td><td>Wickston</td></tr><tr><td></td><td>HOSPITAL OR I age 4 may be received to the contract of the con</td><td></td><td>A STEN GREET SILMEST</td><td>MINSVZIZ</td></tr><tr><th></th><th>TO HOSPITAL OR ATTENDIN Page 4 may be retained to TO FUNERAL DIRECTOR: Afi director, page 3 should to should be filed with the Si</th><th>238</th><th>Ba. BURIAL, CREMATION, 23b. DATE THEREOF, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) - 2 / 8 / 7 / RROVID ENCE CEME GAMBER</th><th>(State)</th></tr><tr><th></th><th>na</th><th>24</th><th>4. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG</th><th>GNATURE</th></tr><tr><th></th><th>VR A15 (4)</th><th>1</th><th>suns G. Sollows WESTMINSTER MODEL FEB 17 1967 Schoole</th><th>& Judge .</th></tr><tr><td></td><td>20M 1/65</td><td>12</td><td>The state of the s</td><td>4 4</td></tr></tbody></table>			



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH filled in by the funeral papers. Pages I and o. COUNTY COUNTY MARYLAND b. CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) WESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Z NAME OF remove carbon Middle Last DATE Day Year signed by the ottending physician ond completely buriol-tronsit permit. Then pleose remov<u>e car</u>bon DECEASED EAR 0F MONROX event, (Type or print) DEATH S. SEX 7. MARRIED 9. AGE (In veors IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH Months Days Hours WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10h. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY **COUNTRY?** SERVICE MAN, OIL BURNERS GAIR CONDITONERS 14. MOTHER'S MAIDEN NAME B. MARTIN Address 16. SOCIAL SECURITY NO. 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH INANITI IMMEDIATE CAUSE (o) DUE TO CARCINOMA Conditions, if ony, which gove rise to immediate cause (o), DUE TO stating the underlying couse the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NGMK NO TO this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour a.m. Not While factory, street, office bldg., etc.) TO FUNERAL DIRECTOR: After 2-22-1967, that (1) (we) last 21. 1 certify that (1) (this hospital) attended the deceased from 2 1966 to be retoined should saw the deceased olive an 2 1967, and that death occurred at 710 AM, fram causes and on the date stoted obove 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. PHYS 22c. PHYSICIAN'S NAME (Type) director, should NAME OF CEMETERY OR CREMATORY 23d. (LOCATION (City or Town) (Stote) 23o. BURIAL CREMATION. REMOVAL (Specify) 2So. REC'D PT REGISTRAR FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE 20 M 1/665

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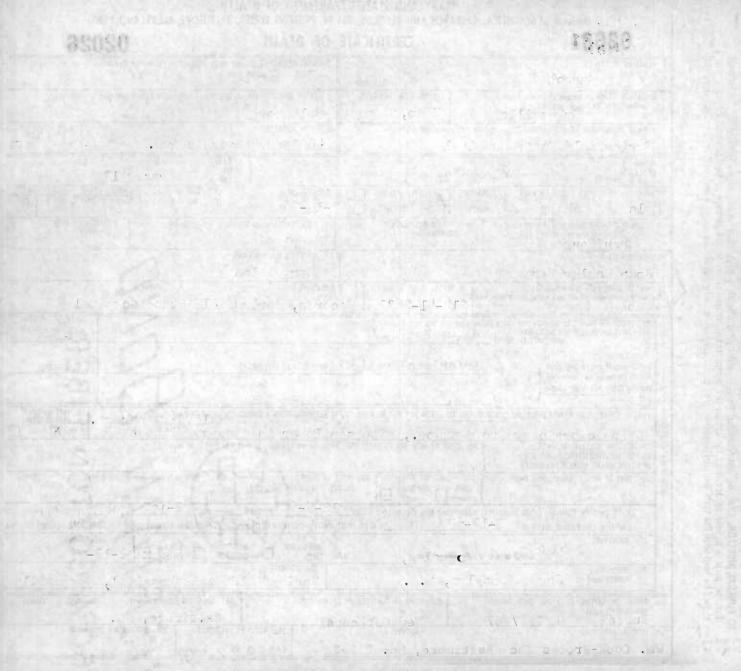


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY Baltimore Carroll MARYLAND 12 P b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Write RURAL end give nearest lown)
Hamos Lead hours Owings Mills d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) . IS RESIDENCE d. STREET ADDRESS ON A FARM? 21 Ritters Lane Black & Decker Mfg. YES NO X 3. NAME OF Middle 4. DATE Month Day Year 72 DECEASED February THOMAS AT.VEY BLATR (Type or print) DEATH 19 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX B. DATE OF BIRTH last birthday) pue death certificate be Months | Days Hours Male WIDOWED [DIVORCED 10a. USUAL OCCUPATION (Give kind of work physician 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 1 12, CITIZEN OF WHAT COUNTRY? done during most of working life, aven if retired) Black & Baltimore. Md. U.S.A. Draitsman 001 esigner 14. ENOTHER'S MAIDEN NAME 13. FATHER'S NAME attending Then please Aurelia M. Dickernhoff James Blair 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Addos Ritters Lane (Yes, ng, or unkown) | (If yas give war or dates of sarvica) Owings Mills, Md. Mrs.Louise B.Blair the law attending physician, 18. CAUSE OF DEATH [Enter only one cause pendina for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which (b) gave rise to immadiata ceuse DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CATION PERFORMED? as o NO X CERTIFIC 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH é 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Homa, farm, (County) (Slata) Month, Day, Year 20f. (City or town) factory, straet, office bldg., etc.) While Not While Hour e.m. at work at work p.m. 21. I certify that (I) (this haspital) attended the deceased from.... and that death occurred at 5.4M, from the causes and on the date stated above. 70 saw the deceased alive on necker 20 1961 223. SIGNATURE ATTENDING MED. STAFF SIGNED DIRECTOR PHYS. KRIVE M.D. HOSPITAL sath. Page 4 FUNERAL ADDRESS 22d. 22c. PHYSICIAN'S NAME (Type) Clarence E. McWill iams ector, filed (Stata) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) Thurmont, Maryland Blue Ridge Cemeter v OH Buri a ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) Owings Mills, Md. DATE

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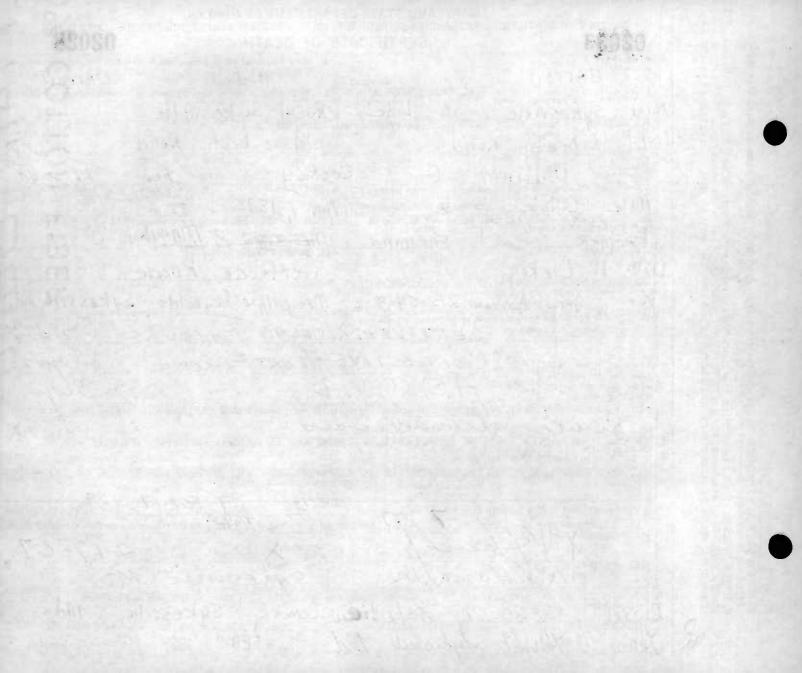
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02031 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 hours after death the attending physician and campletely filled in by the funeral sit permit. Then please semble carban papers. Pages I and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Maryland Carroll (e carban papers. Pages 1 svent, within 72 hours after MARYLAND b. CITY DR TDWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town 2 mo, 8 days Baltimore d STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 1663 Park Heights Ave. Springfield State Hospital YES NO X 3. NAME OF Middle 4. DATE Month Year DECEASED February 13 1957 WILLIAM THOMAS CARTER (Type or print) DEATH IF UNDER 1 YEAR 9. AGE (In years IF LINDER 24 HRS S. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Doys Hours 7-18-86 White Male WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired)
Chauffeur INDUSTRY and Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Wesley Carter Mary Allen 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 21/1-11-7833 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) Heart failure Weeks DUE TO Arteriosclerotic heart disease Conditions, if ony, which gove vears rise to immediate couse (a) DUE TO stoting the underlying couse 4 may be retained by the haspital ar attending has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? phrase. YES X Chronic brain syndrome assoc.. with wenile brain disease without O FUNERAL DIRECTOR: After this certificate 2Do. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, 2Df. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) at work 21. I certify that (1) (this hospital) attended the deceased from 12-5-00 19 2-13 . 1957, that (1) (we) lost sow the deceosed alive on 2-13-67 19 and that death accurred at 3.35 P.M. from causes and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. 2-13-67 M.D. DIRECTOR PHYS director, page 3 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Jorge Gonzales, Springfield State Hospital, Sykesville 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial Baltimore, Md. 2/17/67 New Cathedral 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc Baltimore, Md. 21202



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X		PLACE OF DEATH o. COUNTY	Carroll If outside carporate limits		MARYLAND	o. STATE Mar	(Where deceosed lived, if institution b. COI yland butside carporate limits, write R	UNITY Car	roll
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12			al or institution (if no ld State Ho		give street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES NO SC
		NAME OF DECEASED (Type or print)	Fii Aman		Middle Elizabeth	lost Clark		onth 2 2 IF UNDER 1 YE	Day Year 1967
	1	SEX emale	6. COLOR OR RACE		NEVER MARRIED DIVORCED DIVORCED	12/21/91 1	9. AGE (In yeors lost birthdoy) 76 yrs.	Months Do	Pys Hours Min.
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	13.	FATHER'S NAME	ınknown			Marylan 14. MOTHER'S MAIDEN Neugent			
5	15 (Y	WAS DECEASED EVE es, no, or unknown) no	R IN U.S. ARMED FORCES? (If yes give wor or dotes o	f carviva)		NFORMANT ringfield H	ospital record		sville.Md.
		18. CAUSE OF DI PART I. DEA	EATH (Enter only one cou TH WAS CAUSED BY: IMMEDIATE CAUSE	0					INTERVAL BETWEEN ONSET AND DEATH CLAYS
		Conditions, if ony	e couse (a)	(b) Ne	phrosclerosis				days
		stoting the unde	rlying couse	(c) Dia	abetes Mellitus				years
2	CATION	Chronic	GNIFICANT CONDITIONS C Brain synt wit	ontributing drome	TO DEATH BUT NOT RELATED TO associated with notic reaction.	the terminal disease of	arterioscleros	is	19. WAS AUTOPSY PERFORMED? YES NO
	L CERTIFICATION	OR CONTRIBUTING	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	205. DE	ESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in	n Port I or Port II of item 1B.)		
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			fy that⊅(1) (this hos eceased alive on	pital) atten 2/21	ded the deceased fram_ 1967, and the	t death occurred o	19.66 ta 2/2] at 9:15 M, from causes	/, 19 <u>67</u> and on the	, that 😭 (we) last date stated above.
with bi		220 SIGNATURE	DA B	en I	turnel M.				1/67
shauld be filed with the State Dept. af		22c. PHYSICIAN'S NAME (Type	Naci N	. Buyul	kunsal, M. D.	22d. ADDRESS		laryland	
0	23	BURIAL, CREMATION REMOVAL (Specify	ON, 236. DATE THE 2-23		23c. NAME OF CEMETERY OR White Rock	Cemetery	23d. LOCATION (City or I Sykesvil	le,	unty) (State)
K	2	FUNERAL DIRECTO	W. Haiss	et a	Sykasville 7	2So. TRE	FEB 24 1967	ACLIANT	ATURE Sudge

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. CDUNTY b. COUNTY a. STATE after completely filled in by the 1/10 carbon papers. Pages 1 event, within 72 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH DF STAY IN 1b write RURAL and give nearest town) hours Sukesvil d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? KoAc DAC ND X YES executed within completely NAME DE 3. First Middle Last 4. DATE Month Day Year DECEASEO Cocker (Type or print) DEATH 1967 5. SEX 6. COLOR OR RACE етоме AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED 9. NEVER MARRIED last birthday) Months | any Days Hours WIDOWED X DIVORCED = 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND DF BUSINESS OR INDUSTRY 11. BIRTAPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT ician pe during most of working life, even if retired) COUNTRY? FARMING rmek death certificate FATHER'S NAME MOTHER'S MAIDEN NAME 14. transit permit. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) Sykesvil Spanish-American CAUSE OF OEATH [Enter only one cause per line for (a), (b), INTERVAL BETWEEN ONSET AND DEATH The law requires that the been signed the burial-transit PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) by the hospital or attending physician. da Cenditions, If any, which rise to Immediate stating DUE TO prior underlying cause last. 38 CERTIFICATION S AUTOPSY PART II. DIHER SIGNIFICAN CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAXED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use Health PERFORMED? certificate YE\$ ND PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY DCCURRED, (Enter nature of Injury in Part 1 or Part 11 of Item 18.) detached f te Dept. of DR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) this MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED (State) 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) (County) be de State I factory, street, office bldg., etc.) Hour a.m. After Id be d Not While at work While 19 at work DIRECTOR: A age 3 should lled with the ? 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 2.00 m. from the causes and on the date stated above. saw the deceased alive op-22a. SIGNATURE 22b. DATE SIGNED page . ATTENDING MED. STAFF DIRECTOR PHYS. M.D. FUNERAL PHYSICTAN'S 22c. 22d. ADDRESS director, p NAME (Type) BURIAL, CREMATION, 23b. DATE THEREDF NAME OF CEMETERY OR CREMATORY LOCATION (gity, town or county) (State) 23a. 23d. 2 REMOVALA(Specify) **FUNERAL DIRECTOR** ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR ALS 20M 1/65



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before edmission) e. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) b. CITY OR TOWN (if outside corporate limits. write RURAL end give/néarest town) MONTH IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress d. STREET ADDRESS ON A FARM? YES NO. 3. NAME OF Middle DATE Month Day Year Last DECEASED OF DEATH (Type or print) 1961 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 8. DATE OF BIRTH last birthday) Months Hours WIDOWED' 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO. 17. INFORMAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES?" (Yes, no, or unkown) | (If yes give wer or detes of service) гетома 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (e), stating the underlying ceuse last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20b, DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Part I or Pert II of item 18.) 208. ACCIDENT WAS UNDERLYING T OR CONTRIBUTING A CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) While Not While Hour e.m. at work el work p.m. 21. I certify that (I) (this hospital) attended the deceased from / - 10 1961, to 2 1961, that (1) (we) last 22b, DATE SIGNATURE 22e. SIGNED ATTENDING DIRECTOR PHYS. 22d. ADDRESS. 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 0 Suria 256. REGISTRAR'S SIGNATURE 25e. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE

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(MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RYLAND
	02037 CERTIFICATE OF DEATH mh 021	132
1.	PLACE DF DEATH a. COUNTY CARRO 2. USUAL RESIDENCE (Where deceased lived, If institution: Res a. STATE b. COUNTY CARRO	idence before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	nd give nearest town)
	d. NAME OF HOSPITAL OF INSTITUTION (if not in hospital, give street address) FIRST HVE SHIFTS WILLIAM SHIFT	8. IS RESIDENCE ON A FARM? YES NO 2
3.		Day Year 5, 1967
	10111111 WIDOWED DIVORCED NOV. 10, 1883 83 yrs.	
dur	Housewife Home MARYANA	IZEN OF WHAT INTRY? . S. A
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15 (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? s, no, or unknown) (If yes give war or dates of service) ? Informant Address ? MAE Pullen - Sykes ville,	md.
	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, Cardiac failure,	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, If any, which gave rise to immediate (b) Carcinoma of the bowel, arteriosclerosis, gen-	through
NOI	underlying cause last. (c) erlized: Chronic Brain Syndrome. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
RTIFICAT	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH	YES NO
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. While Not While factory, Street, office bldg., etc.)	ty) (State)
M	21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to Feb. 15., 19 6	7, that (I) (we) last
	22a. SIGNATURE HOLD STAFF 22b. DAT MED. ATTENDING DIRECTOR PHYS. Feb.	15, 1967
	NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland	
·	BUNIAL BOOCHTY) 2-18-67 Freedom Cemetery Sykesville,	Mel -
24	Harry W. Haight Syusville Md. DATE EB 2 0 1967 fileste	s Judge
	3. 5. 1Dad dur 13. 15 (Ye	1. PLACE DE DEATH 2. USUAL RESIDENCE (Where deceased lives, H institution: Res 3. STATE 3. C. LENGTH OF STAY IN 10 D. CITY OR TOWN (If outside corporate limits,

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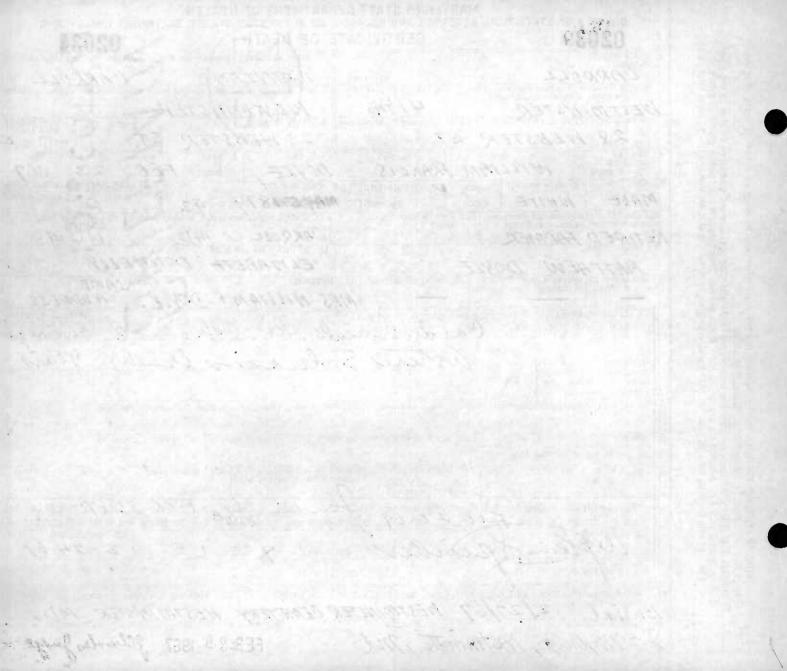
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02038 deoth. 2 be executed within 24 haurs after death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and burial, cremation, ar remaval, and in finy event, within 72 hours after degt o. COUNTY b. COUNTY o. STATE Allegany Carroll Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 1h c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) Rural -- Sykesville 3m. 26d. Lonaconing d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Springfield State Hospital 36 E. Main Street YES NO X 3. NAME OF Middle First Lost 4. DATE Month Year DECEASED 19 67 Evelyn 16 Ruth Dick (Type or print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 7. MARRIED NEVER MARRIED Jost birthdoy) Months Doys Hours 1,/8/19 white female WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? **INDUSTRY** USA requires that the death certificate Maryland factory worker 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James Russell Dick Bertha Bishop 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service 212-12-8299 Springfield Hospital records, Sykesville, Md. no CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN WEEKS DEATH PART I. DEATH WAS CAUSED BY Heart failure IMMEDIATE CAUSE (o) DUE TO Coronary artery arteriosclerosis and insufficiency vears Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse as the prior to b Page 4 may be retained by the haspital or attending lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? has Chronic brain syndrome associated with Huntington's Chorea without qualifying phrase. of far use of Health YES 🕌 NO FUNERAL DIRECTOR: After this certificate 200. ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work 10/20/ 1961 10 , 1967, that PA (we) lost 21. I certify that 30 (this hospital) attended the deceased from 2/16/ director, page 3 shauld shauld be filed with the 19 67 , and that death occurred at \$152M, from couses and on the date stated above. 2/16/ sow the deceased olive on. 22b. DATE SIGNED 220 SIGNATURE ATTENDING X 2/16/67 M.D. DIRECTOR PHYS. PHYS Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Naci N. Buyukunsal. M.D. Sykesville, Maryland 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Burial (Specify) Lonaconing MD 19 Hill 9 Oak Cemetery 24. FUNERAL DIRECTOR 256. REC'D BY REGISTRAR Charles VR A15 (4) 1967 GEORGE EICHHORN Lonaconing, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

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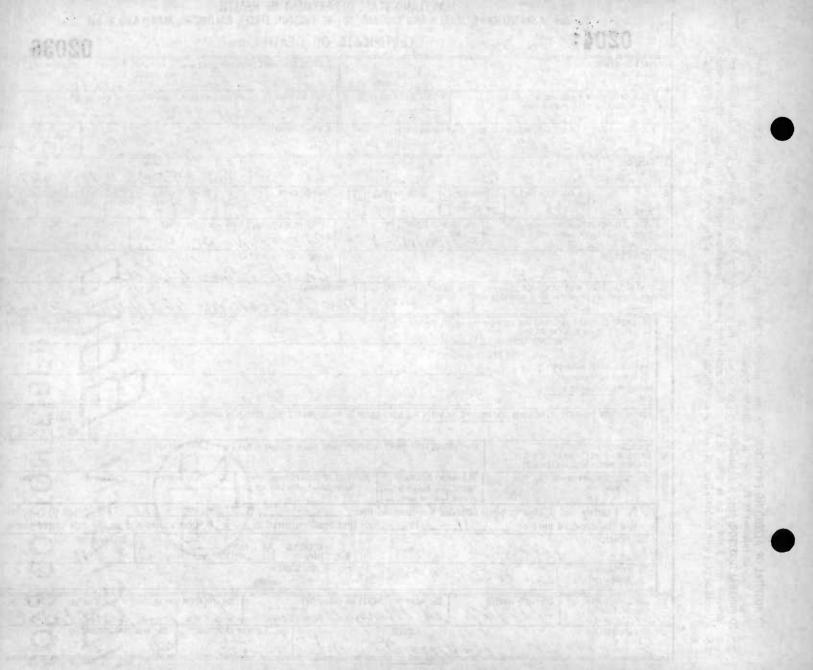
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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
24	02039 CERTIFICATE OF DEATH 02034
	1. PLACE OF DEATH a. CQUINTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission a STATE b. CQUINTY
	CARROLL MARYLAND MARROLL
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS. RESIDENCE
0	28 WEBSTER ST. 28 WEBSTER ST. YES NO NO
1	3. NAME DF OECEASED (Type or print) WILLIAM FRANCIS DOYLE DEATH FEB. 23 1967
	5. SEX 6. COLOR OR RACE 7. MARRIED 7. MARRIED 8. OATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR
	MALE WHITE WIDOWED DIVORCED MAY 5 1874 92 yrs. Months Days Hours Min
	10a. USUAL DCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR during most of working life, even if retired) 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT COUNTRY?
	RETIRED FARMER C'ARROLC COMD. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ı	MATTIFIAL DOUF ELIZABETH DONNELLY
ŀ	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address CAME
1	(Yes, no, or unkown) (If yes give war or dates of service) MRS WILLIAM F-DOYLF, ADDRESS
1	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
	PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal Lusland Seular y
	DUE TO (1) Service (Co. O) General
	Conditions, If any, which gave rise to Immediate (b) Which Schlases Cherch Jensey
1	cause (a), stating the OUE TD underlying cause last. (c)
I	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
ı	ਤੂੰ YES □ NO D
	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO SERVICE OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
١	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) (County) (State)
1	Hour a.m. p.m. 19 While at work at work
Ī	21. I certify that (I) (this hospital) attended the deceased from 10, 1964 to Feb 231967, that (I) (we) last
	saw the deceased alive on Fell 2 279 67, and that death occurred at \$150 M, from the causes and on the date stated above 22a. SIGNATURE 122b. OATE SIGNED
١	When peoches M.O. ATTENDING MED. STAFF 220 ONE STAFF 2 2-24-67
١	22c. PHYSICIAN'S 1 22d. ADDRESS
I	NAME (Type)
	23a. BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	2. 2. much & westminter, md. DATEFFB 28 1967 Icharles Judge
-	1 - Illahold Illahold Illahold Indiana

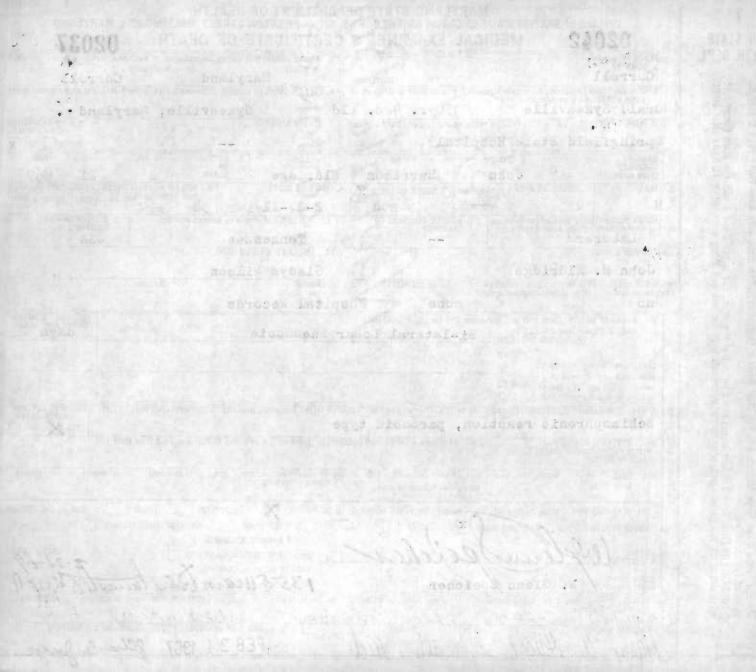


5	1	No.	MARYLAND STATE DEPARTMENT OF HEALT DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREE	
÷	₽04 1		02040 CERTIFICATE OF DEATH	02035
nours after death	uner and deat		o COUNTY	eased lived, If institution: Residence before admission)
ter	s 1		Carroll MARYLAND Md.	b. COUNTY Carroll
S	by t		write RURAL and give nearest town)	orate limits, write RURAL end give nearest town)
Juon	S. Found		Hampstead d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS	A LO DECIDENCE
242	ng physician and completely filled in by the funeral Theorphase remove carbon papers. Pages 1 and 2 moval, and in any event, within 72 hours after death.	00	22) 16-1-	et e. IS RESIDENCE ON A FARM?
ië	or attending physician. sate has been signed by the attending physician and completely ruse as the burial-transit permit. Their please remove carbon is alth prior to burial, cremation, or removal, and in any event, with		3. NAME DF First Middle Last 4. DATE DECEASED (Type or print) Blanche J. Eburg DF DEATH	Month Day Year
× 5	mple cart ent,			February 4, 19 67
cute	d co love y ev		5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9.	AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min.
exe	rem n an		Female White WIDOWED DIVORCED Jan. 31, 1902 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State,	Ob yrs.
be	ician ase ind i		during most of working life, even if retired) INDUSTRY	or foreign country) 12. CITIZEN OF WHAT CDUNTRY?
cate	a pre		Housewife West Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	OSA
THE PERSON NAMED IN	ofing p Then remova		John W. Frush Lula Belle Sm	ith
S	tend nit. or re		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)	Address
leat	the attend t permit. ation, or re		No Mr. Charles E. Eburg	
9	lan. d by the al ransit perr cremation,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
at t	clan. led by t transit I, crema		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cum any Thumbon	nin
as th	physician. n signed by burial-transi		Conditions, If any, which DUE TO INTERNO - Sawhi CV. Da	was Enlyes
aulr	ding p been the bu		gave rise to immediate	
W re	tendinas possible as the prior		underlying cause last. (c)	
9	e he se	2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND	OITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
		-	2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pa	YES NO
PHYSICIAN:	the hospital or attending this certificate has been detached for use as the be Dept. of Health prior to the		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS 2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pa OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	t for Part II of Item 16.)
HYSI	he hos this ce etache Dept.			City or town) (County) (State)
2			20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, officebldg., etc.) While at work at work	1 14
ATTENDING	Af A		21. I certify that (1) (this hospital) attended the deceased from 3-25 1960, to	2-4, 19 1, that (I) (we) las
	be retained IRECTOR: A ge 3 should ed with the	34		m the causes and on the date stated above
2	d v d	20	222. SIGNATURE M.D. ATTENDING MED. DIRECTOR [STAFF 22b. DATE SIGNED
1	AL DIR page e filed	3	22c. PHYSICIAN'S 22d. ADDRESS	PHYS. LI 2-0-4
SPI	NER Ctor,	1	NAME (Type) M. C. Porterfield Hampstead, Md	
25 0	Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 shoul should be filed with the		REMOVAL (Specify)	CATION (City, town or county) (State)
	F	0	Burial 2/7/67 Hampstead Cemetery Ha	mpstead, Md. TRAR 25b. REGISTRAR'S SIGNATURE
	VR A15 (4) N	1	Tinton-Fline Funeral Home Hampstead Md.	4007 W
	15M 4-64	,	DATE FEB 8	1301 grante Judge

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE CERTIFICATE OF DEATH MEDICAL EXAMINER'S HEALTH DEPT USVAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) PLACE OF DEATH a. COUNTY Carroll b. COUNTY Maryland Carroll MARYLAND the funeral may be Department after death c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 30vr. 4mo. 21d (Rural) Sykesville Sykesville, Marvland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 10 any delay is 2, and 3 to t PM3. Page State hours Springfield State Hospital YES T NO 3 NAME OF First Middle Last 4. DATE Month Day Year the DECEASED John Harrison Eldridge DEATH 1967 (Type or print) 2 with AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX DATE OF BIRTH EXAMINER: This certificate should be executed within 24 hours after death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, nould be forwarded to the Chief Medical Examiner's Office along with form 6. COLOR OR RACE | 7. MARRIED NEVER MARRIED 3 last birthday) Months | **Davs** Hours M OIVORCED T 2-27-11 1910 56 WIDOWED and 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA Laborer Tennessee 13. FATHER'S NAME MOTHER'S MAJOEN NAME John H. Eldridge Gladys Wilson File 15. WAS OECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes, no, or unknwn) | (If yes give war or dates of service) permit. F Hospital Records no none INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit cremation, or Bi-lateral Lobar Pneumonia IMMEDIATE CAUSE (a) DUF TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the ca used as a to burial, underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY CERTIFICATION PERFORMED? Schizophrenic reaction, paranoid type YES X NO should be 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 3 shou agent, MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. While Not While at work CTOR: Page designated at work 21. I certify that I took charge of the remains described above, held an Autopsy Inquiry and in my opinion Inspection the cert es. RECTOR: Undetermined manner death resulted from: Natural causes Accident Suicide Homicide CHIEF MEDICAL EXAMINER your 4 execute Page 4 ASSISTANT MEDICAL EXAMINER SIGNATURE 0 10 for DEPUTY MEDICAL EXAMINER TX FUNERAL Health DEPUTY **EXAMINER'S** director. Glenn Speicher NAME (Type) LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION.I DATE THEREOF 23c. REMDVAL (Specify) 0 MAtion 10 26b. REGISTRAR'S SIGNATURE INERAL DIRECTOR VR A15ME 3500 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02043 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death the attending physicion and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages 1 and sit permit. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY Carroll a. SMaryland b. COUNTY remove carbon papers. Pages 1 injour event, within 72 hours after MARYLAND Washington b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Hagerstown Lyr.8mos.22dys Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 1059 Florida Ave. NO T Springfield State Hospital Middle 3. NAME OF 4. DATE Last Year DECEASED OF DEATH WALTER ENSOR 67 FRANKLIN FEBRUARY 19 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED olast birthday) Manths Haurs Days Male White 9-2-07 WIDOWED 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) **INDUSTRY** U.S.A Maryland
14. MOTHER'S MAIDEN NAME None 13. FATHER'S NAME Howard Ensor Alva B. Fogle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, ar unknawn) (If yes give war ar dates af service) 218-24-Records, Springfield State Hospital None 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE (AUSE (a) Cardiac arrest Conditions, if any, which gave Hours (b) Acute myocardial infarction rise to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been os the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Schizophrenic reaction, chronic undifferentiated type 19. WAS AUTOPSY PERFORMED? NO X Po 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Nat While at wark pe 21. I certify that (1) (this haspital) attended the deceased fram 5-28-65 saw the deceased glive an 2-20-67 19 and that death accurate and that death accurred and 2-20-67, 19___, that (I) (we) last M, fram causes and an the date stated above. should saw the deceased alive an. 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. 2-21-67 X M.D. DIRECTOR director, poge should be filed Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY (State) 23b. DATE THEREOF (Caunty) 23a. BURIAL, CREMATION, REMOVAL (Specify) VR A15 (4) 20 M 1/66

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3. NAME OF BECERSED First Middle Last 4. DATE Month Day Year DECERSED Type or print J. F. R. L.	b. CITY OR TOWN If doubles corporate limits, write RUNAL and properly limits, write RUNAL and you magast bown) WITH AMAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) J. NAME OF DECRASED (If you or print) J. S. SEX 6. COLOR OR RACE 7. MARRIED PRIVER MARRIED 18. DATE OF BRITH 19. OBATE WIDOWSD DIVORCED		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M. 02044 CERTIFICATE OF DEATH	2039
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. NAME OF AND STATE ADDRESS AND STATE ADD	d. NAME OF HOSPITAL OR INSTITUTION (if not in baspital, gives street address) J. NAME OF HOSPITAL OR INSTITUTION (if not in baspital, gives street address) J. NAME OF HOSPITAL OR INSTITUTION (if not in baspital, gives street address) J. NAME OF HOSPITAL OR INSTITUTION (if not in baspital, gives street address) J. S. SEX S. COLOR OR RACE (7, MARBIED HYRVER MARBIED DATE OF BRITE DATE DATE	1.	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURALT and g	roll
3. NAME OF DECEMBED FIRST Middle Last 4. DATE Month Day Year DEATH F. D. DEATH F. D. DEATH F. D. DEATH F. D. DEATH P. D. DEATH D	S. SEX G. COLOR OR RACE J. MARBED PTEVER MARRIED S. DATE MORTH J. AGE (In year) IF UNDER 1 YEAR J. AGE (IN YEAR)	00	Watningto & Watnington	e. IS RESIDEN ON A FAR YES NO
10s. USUAL OCCUPATION (Give hind of work don guing-page) of york. 10s. USUAL OCCUPATION (Give hind of work don guing-page) of york. 10s. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Cgdniy & Sinle, or loreign country) 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME 13. FATHER'S NAME 13. FATHER'S NAME 14. MANUAL AND STANDARD FORCES 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH (Enter only one cause par line for (a), (b), and (c). 18. CAUSE OF DEATH (Enter only one cause par line for (a), (b), and (c). 18. CAUSE OF DEATH (Enter only one cause par line for (a), (b), and (c). 18. CAUSE OF DEATH (Enter only one cause par line for (a), (b), and (c). 18. CAUSE (a), stating the underlying 19. WAS AULT 19. WAS	No. USUAL OCCUPATION (Give kind of work of the country) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Codiny & Shift, or Identify) 12. CITIZEN OF WHAT COUNTRY of the country		DECEASED LE ROY OLIVER FARVER OF DEATH FEB.	Pay Year 1967
13. FATHER'S NAME 15. WAS DECEASED EVERIN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. 17. INFORMANT Address A	15. WAS DECEASED EVEN U.S. ARMED FORCES? IG. SOCIAL SECURITY NO. 17. INFORMANT 16. WAS DECEASED EVEN U.S. ARMED FORCES? IG. SOCIAL SECURITY NO. 17. INFORMANT 17. MACHIER'S MAIDEN NAME 18. CRUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] PART I. DEATH WAS CAUSED BY: MINISTRYAL BETW. DUE TO Conditions, if env, which geve rise to immediate cause [a), stelling the underlying [c] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUT PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUT DUE TO CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF CAUSE OF THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUT OF CONTRIBUTING CAUSE OF	10	March 30 /890 (gy yrs. WIDOWED DIVORCED March 30 /890 (gy yrs.) B. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Codniv & Sialk, or loreign country) 12. CITIZE	ys Hours Mi
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] PART I. DEATH WAS CAUSED BY: COUNTY OF COURTS IMMEDIATE CAUSE (e)	18. CRUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gave rise to immediate cause [a), staining the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUT PERFORM YES NOT	1	three summer swatchmant everfaction Carrolle, mil. 4	-S.A.
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21. I certify that (I) (this hospital) attended the deceased from	21. I certify that (I) (this hospital) attended the deceased from		(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Young You) (Stat
ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 2/18/6	22c. PHYSICIANS DATE THEREOF, 23c. NAME OF CEMETERY OR CREMATORY ATTENDING MED. STAFF DIRECTOR STAFF DIRECTOR		21. I certify that (I) (this hospital) attended the deceased from 2/4, 1963, to 2/14, 1963	date stated al
	23a. BURIAL, CREMATION, 23b. DATE THEREOF, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State		M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 22d. ADDRESS	2/14/2

MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death. 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) PLACE DF DEATH the h a. COUNTY b. COUNTY after MARYLAND in by the S. Pages hours after b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) hours MIB bon papers. within 72 ho d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? 24 YES NO completely to 3. NAME OF First Middle DATE Month Day Last 4. DECEASED 0F event. (Type or print) DEATH 196 AGÉ (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. last birthday) | Months | Days | Hours | Min. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED [NEVER MARRIED remove Days Hours any and WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 12. CITIZEN OF WHAT .= 10b. KIND OF BUSINESS OR (County & State, or foreign country) physician lease and in certificate be during most of working life, even if retired) INDUSTRY COUNTRY3 0 FATHER'S NAME MOTHER'S MAIDEN NAME remova attending ed by the attend transit permit, cremation, or re-G. STANS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMAN' death (Yes, no, or unkown) (If yes give war or dates of service) MRSI AIRY CAUSE OF DEATH [Enter only one cause per-line for (a). INTERVAL BETWEEN ONSET AND DEATH igned by rial-transi PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) been signed the burial-tr or to burial, (DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the prior underlying cause last. as WAS AUTOPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. for use Health PERFORMED? certificate YES NO P PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) t. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detach this MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or towp) (County) (State) be de State factory, street_office bldg., etc.) Hour a.m. Not While After at work at work p.m. retained DIRECTOR: A age 3 should led with the 0 21. I certify that (I) (this hospital) attended the deceased from M, from the causes and on the date stated above. saw the deceased alive on and that death occurred a 22b. 22a. SIGNATURE pe page if filed ATTENDING PHYS. STAFF PHYS. M.D. DIRECTOR HYSICIAN'S 22d. **ADDRESS** FUNERAL director, p 22c. NAME (Type) BURIAL, CREMATION, REMOVAL (Specify) LOCATION (City, town or county) (State) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. FUNERAL DIRECTOR REGISTRAR 25b. REGISTRAR' 25a. REC'D BY 6 VR A.15 (4) DATE 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 naurs after death: requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY a. STATE. b. COUNTY Marvland Carroll Carrol] MARYLAND b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) npletely filled in by the carban papers. Page vent, within 72 haurs a write RURAL and give nearest town) 2 Months Sykesville Rural Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS YES INO Gen Hospital Rt. 3. NAME OF Middle Last 4. DATE Month Day Year and campletely DECEASED 1967 Feb. Horatio Stanley DEATH (Type or print) 9. AGE (In years IF UNDER 1'YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED remave n any eve birthday) Manths Days Haurs DIVORCED 2-15-1899 WIDOWED Male White 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) INDUSTRY COUNTRY? physician and please during mast of warking life, even if retired) pup Building Ohio Building 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, Sarah Bangs Harry Fox the attending passit permit. The 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service) signed by the atter burial-transit permi burial, cremation, a Sykesville, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) DUF TO Canditions, if any, which gave rise to immediate cause (a). DUF TO stating the underlying cause has been detached far use as the te Dept. af Heolth prior ta WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO TO FUNERAL DIRECTOR: After this certificate by the haspital or 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) Not While While at wark at wark 21. I certify that (1) (this haspital) attended the deceased from Dec 26, 1966, ta Feb 27, 1967, that (1) (we) last be retained saw the deceased alive an Feb 27 1967, and that death accurred at 93M, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING director, page 3 shauld be filed v M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Westmins HARSHEY 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23a. BURIAL CREMATION (County) REMOVAL (Specify) easant 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1967 DATE

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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	02048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02043
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY Carroll 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Baltimore City
o the funeral e 5 may be Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
ma mart	Sykesville Lyrs. 8mos. 4dys. Baltimore 30-4
Page 5 to the Pa	ON A FARM?
State hours	Springfield State Hospital 603 Wyeth St. YES NO NO NO NO NO NO NO N
the	OFF OF OFF OFF OFF OFF OFF OFF OFF OFF
ges 1, 2 form P 2 with within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Jast birthday) Months Days Hours Min.
ages ages of foll of 2	Female White WIDOWED DIVORCED 7-3-24 42 yrs.
or deal	10a. USUAL OCCUPATION (Give kind of workdone down the following most of working life, even if retired) 10b. KIND OF BUSINESS OR during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) COUNTRY? Warvland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
S. G.	None Maryland U.S.A. 13. FATHER'S NAME
m 1 se a	Frederick Gorth Edith Marney
24 ho office Office File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no. or unknown) (If yes give war or dates of service)
within 2 pencil in miner's C permit.	No None Records, Springfield State Hospital
d wind min per amin per amin per t per ren	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the entire bronchus Minutes to
Extra ansit	9217 IMMEDIATE CAUSE (a) ASPRIYATE due to occurrent of the entire proficing Minutes to
e exe indin dica laf-tr natio	Conditions, if any, which \ (b)
uid be executed "pending" in stranger in Medical Exama burial-transit cremation, or	gave rise to immediate cause (a), stating the DUE TO
shou vord Chief as a rial,	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 19. WAS AUTO
EXAMINER: This certificate should be executed within 24 hours after death. If any delectificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and hould be forwarded to the Chief Medical Examiner's Office along with form PM3. Isles. OR: Page 3 should be used as a burial-transit permit. File pages, and 2 with the St isignated agent, prior to burial, cremation, or removal, and in any event within 72 ho	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) PERFORMED? YES PERFORMED? YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 11 of Item 18.) PRIMARY OF CONTRIBUTING BECAME Cyanosed & suddenly stopped breathing. The doctor CAUSE OF DEATH.
ntifficant to to to to to to	200. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING Became cyanosed & suddenly stopped breathing. The doctor
ER. This certificate, writing forwarded to 3 should be agent, prior i	
te, Thi	Cause of Death. Was called, who gave emergency care, but to no avail. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Soft actory, street, office bldg., etc.) While Not While at work at work Clark Circle Sykesville Carroll Maryland
INER iffica be 1 ge 3 ed a	p.m. 2-23-1967 at work at work Clark Circle Sykesville Carroll Maryland
the certificate should be should be in files.	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes . Accident . Suicide , Homicide , Undetermined manner
	CHIEF MEDICAL EXAMINER
	ACTUAL SIGNATURE SIGNATURE CONTROL SIGNATURE CON
fo fo	EXAMINER'S IN Glann Speicher M. D.
D DEPUTY N please exe director. P retained fo 3 FUNERAL of Health	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
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B	24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE 25c. REC'D BY REC'D BY REGISTRAR'S SIGNATURE 25c. REC'D BY REGISTRAR'S SIGNATURE 25c. REC'D BY REGISTRAR'S SIGNATURE 25c. REC'D BY REC'D BY REGISTRAR'S SIGNATURE 25c. REC'D BY REC'D BY REC'D BY REC'
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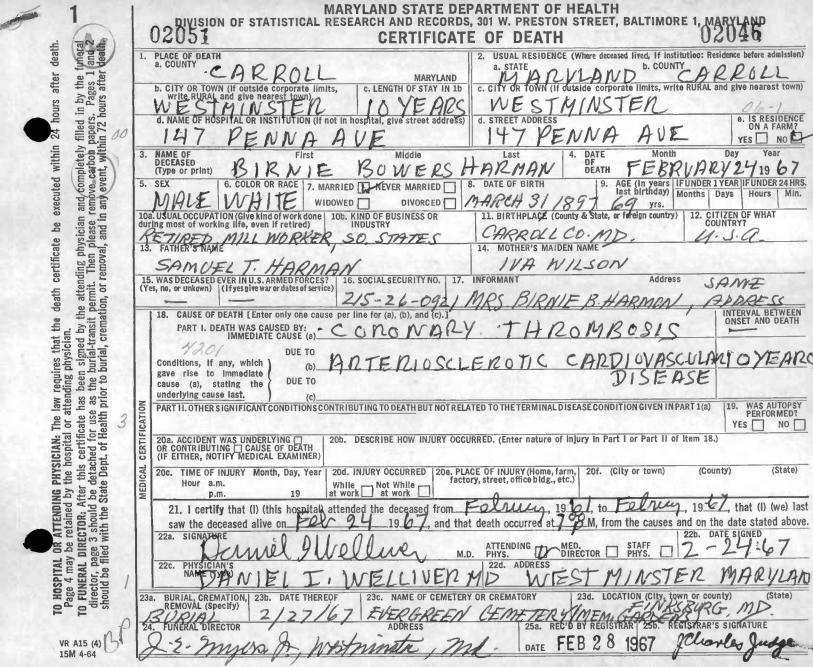
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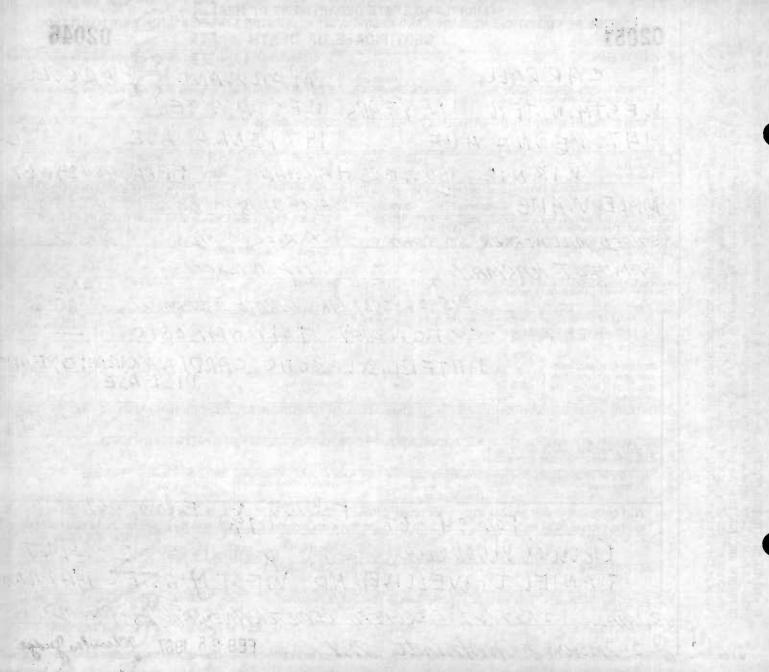
FOR STATE HEALTH DEPT. The composition of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND OCCUPATION CONTROL OF THE COUNTY OF TOWN IT GUIDAL COUNTY IN THE COUNTY IN
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d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET AGORESS A. STREET AGORES A. OATE AGORT
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S. SEX 6. COLON OR RACE 7. MARRIED NEVER MARRIED NAY 23 - 1903 Set birthday) Nat birthday Nat bi
WIDOWED OVORCED WAY 33-793 C3 yrs. 10a. USUAL OCCUPATION (Clive kind of work done) 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITYNO. 17. INFORMANT 17. INFORMANT 18. CAUSE OF BEATH [Enter only one cause per tiple for (a), (b), and (c), 1 18. CAUSE OF BEATH [Enter only one cause per tiple for (a), (b), and (c), 1 18. CAUSE OF BEATH (Enter only one cause per tiple for (a), (b), and (c), 1 18. CAUSE OF BEATH (Enter only one cause per tiple for (a), (b), and (c), 1 19. WAS AUTOPSY PART II. DEATH WAS CAUSED BY: 19. Unique to the underlying cause last. 19. Unique to the underlying cause last. 19. Unique to the underlying cause last. 19. WAS AUTOPSY PERFORMED? YES NO 20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE (A) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) 20c. TIME OF INJURY Month Only Yes 1 and INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) 20c. TIME OF INJURY Month Only Yes 2 and INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.)
during most of working life, even if retired) EMPLOYEE HOTEL 14. MOTHER'S MAIOEN NAME LENORA FICK 15. WAS DECEASED EVER IN U.S. ARMEDFORCES? (Yes, no, or unknown) (If yes give war or dates of service) 15. WAS DECEASED EVER IN U.S. ARMEDFORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (b), staffing the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED? YES IND INTERVAL BETWEEN OF THE ORD CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED? YES IND INTERVAL BETWEEN OF THE OF DEATH. 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) 20c. THAT OF THE OF T
13. FATHER'S NAME LENORA FICK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT LENORA FICK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT LENORA FICK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 2/2-/2-70/7 FLORENCE GRAY BALTIMORE 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) DUE TO Conditions, If any, which Service The part is to immediate cause (b), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20s. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING ONLY YEAR 20d INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month Only Year 20d INJURY OCCURRED. (20e PIACE DE INJURY (Bone) farm 20d (City or town) (County) (State)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANI 17. INFORMANI 18. WAS DECEASED EVER IN U.S. ARMED FORCES? 18. SOCIAL SECURITY NO. 17. INFORMANI 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II of Item 18.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II of Item 18.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II of Item 18.) 19. WAS AUTDPSY PERFORMED? YES NO PRIMARY TO CONTRIBUTING TO CONTRIBUTING TO COURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 202. EXTERNAL CAUSE WAS PRIMARY TO COURRED. (202 PLACE DE INJURY (Home farm 1205 (City or town)) (Stata)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Underlying cause last. OCCUMENTAL BETWEEN ONSET AND DEATH Success ONSET AND DEATH ONSET
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PRIMARY Or CONTRIBUTING 200b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20b. TIME OF INVIEW Month Only Year 1 20d. INVIEW OCCURRED. (20b. PLACE OF INVIEW (Home farm 1 20f. (City or town) (County) (State)
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO X 10 10 10 10 10 10 10 10 10 10 10 10 10
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CAUSE OF DEATH. STATE OF TIME OF INITIAL Month Cox Year 20d INITIAL OCCUPRED 20e PLACE OF INITIAL (Home farm 20f (City or fown) (County) (Stata)
20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. p.m. 19 at work at work
21. I certify that I took charge of the remains described above, held an Autopsy [], inspection [X], Inquiry [], and in my opinion
p.m. 19 at work at work
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE SIGNED ACTUAL SIGNATURE SIGNATU
ACTUAL SIGNATURE ACTUAL SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEP
SPEICHER Adeles STEPHEN SPEICHER Adeles STEPHEN SOURCE STEPHEN
SIGNATURE
PARTIES ADDRESS PART UNION BRIDGE RURAL MD
VR A15ME DD Hartzler V Sons Union Bridge, Md DATEFB 2 3 1967 Televiles Judge

ELMER LAWRENCE GRAYSE IN FEB. 18 The second Comment Sellanie When to Gran The first series 1 22 Education

- 1	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
	a. COUNTY e. STATE b. COUNTY
ent be	Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)
is necessary, o the funeral e 5 may be Department after death.	Sykesville 2 yrs. ll mos. Silver Spring /5-2
Depz ifter	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
Adelay is not 3 to Page State L hours a	Springfield State Hospital 10409 Rodney Road YES NO
ab Se	3. NAME OF First Middle Last 4. DATE Month Day Yeer DECEASED OF GOLD O
E-28 +-	(Type or print) Margaret Howe Greene DEATH 2/10/67 19 67
th. If a form P form P within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min.
age 1 to 1 to 1 to 1	Female White WIDOWED DIVORCED 1/11/23 July yrs.
ive Pa with with I and	during most of working life, even if retired) INDUSTRY
afte ong ong ss 1 nny o	House wife Own home Oregon U.S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ours aftu n 18. G e along pages 1 in any	Pobert
24 ho Item Office and	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SUCIAL SECURITY NO. 1 L/. INPURMANT
n 2 l in s 0 s 0 ral,	(Yes, no, or unknown) (If yes give war or dates of service) [21 16 1760] [rnest Greene 9611 New Hampshire Hue.
d within pencil in miner's miner's permit.	1 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c) 1
CAL EXAMINER: This certificate should be executed within 24 hours after death. If a the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, the certificate, writing the word "hedical Examiner's Office along with form or files. ECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 within sesignated agent, prior to burial, cremation, or removal, and in any event within	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS Dh / X L Q ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS Dh / X L Q
I'd be executed I "pending" in If Medical Exar a burial-transit cremation, or	355 X DUF TO 1
e ex endii edica ial-t	conditions, if any, which 1 (b) OCC (1181000) Nose and mouth by bitou min.
d bd "pe "pe "pe bur cren	gave rise to immediate cause (a), stating the DUE TO
shoul ford Chief as a ial,	underlying cause last. Pre-senile degeneration of the brain Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PROPERTY.
ficate sho the worn the Chi used as to burial	PERFORMED:
rtificand that the toto to to to to	Schizophrenie reaction Chronic undicterentiated to be 2012 DESCRIBE HOW INJURY OCCURRED. (Enter neture of fillury in Part I or Part II of Item 18.)
cerritin ded ld b prio	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of Injury in Part I or Part II of Item 18.) PRIMARY or CONTRIBUTING CAUSE OF DEATH.
R: This cer cate, writir forwarded 3 should k agent, pri	
for for age	20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work to the work to p.m. 19 20d. INJURY OCCURRED to PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) to the p.m. 19 20d. INJURY OCCURRED to p.m. 20f. (City or town) (State)
Page ated	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry, and In my opinion
AL EXAMINE the certific the certific. I should be r files. CTOR: Page designated	death resulted from: Natural causes , Accident , Suicide , Homlcide , Undetermined manner
IEDICAL EXP cute the c age 4 shou r your files DIRECTOR: r its design	CHIEF MEDICAL EXAMINER
THO OF THE	ACTUAL SIGNATURE (CENTRAL) PROBLEM M.D. ASSISTANT MEDICAL EXAMINER 7-10-67
TA N A To L To	EXAMINER'S NAME (Type) CO and Special of the M. D. Address Green by the green, by document from the control of the control
lo DEPUTY MEI please execution please execution Pag director. Pag retained for yo Funeral Di of Health or i	NAME (Type) Glenn Speicher M.D. Address Green and College Proceedings of College Procedure Proceedings of College Procedure P
of Line	REMOVAL (Specify)
	24. FUNEBAL DIRECTOR SAPORESS 256. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
VR A15ME	Warner E. Pumphrey, Inc. Silver Spring Md. DATE FEB 16 1967 y Charles Judge
3500 4-64	The state of the s

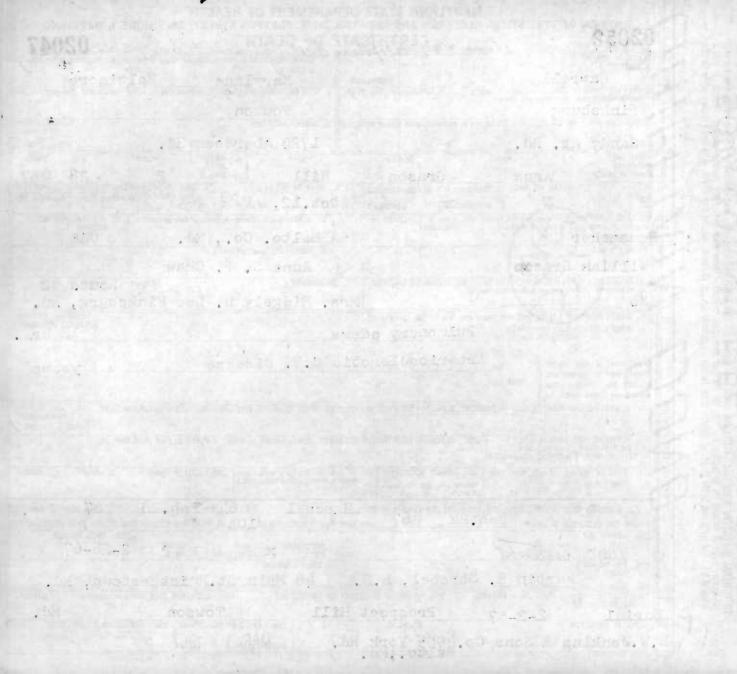
land to the many on the Police of the land of the land of the light of the land of the lan Account ago to de a la maria Such 15. 1867 - Cheller Belleville (Breise at Belleville) between and Reposed tells ... A free Western C. Fluidheau, Direc Selaina Seeing, 1835, a. an 1833 and 1866.



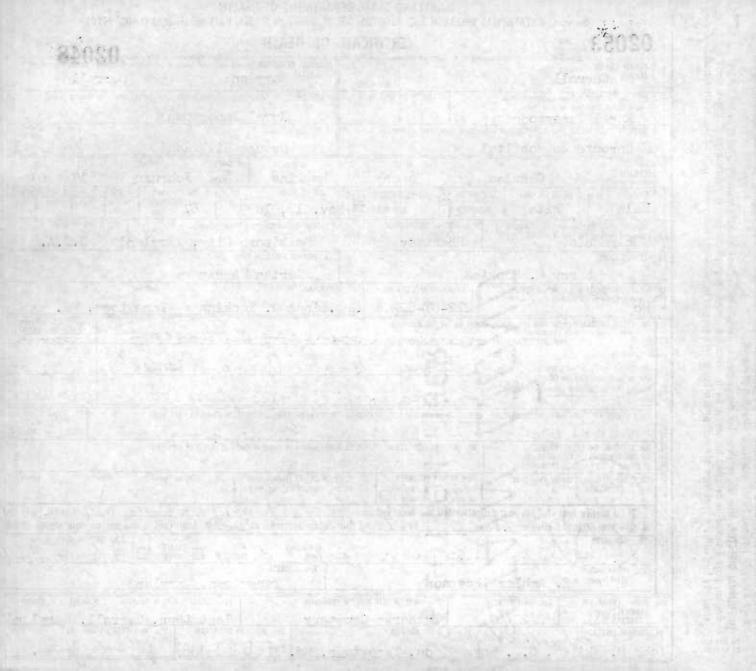


VR AIS (4) 20M I/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

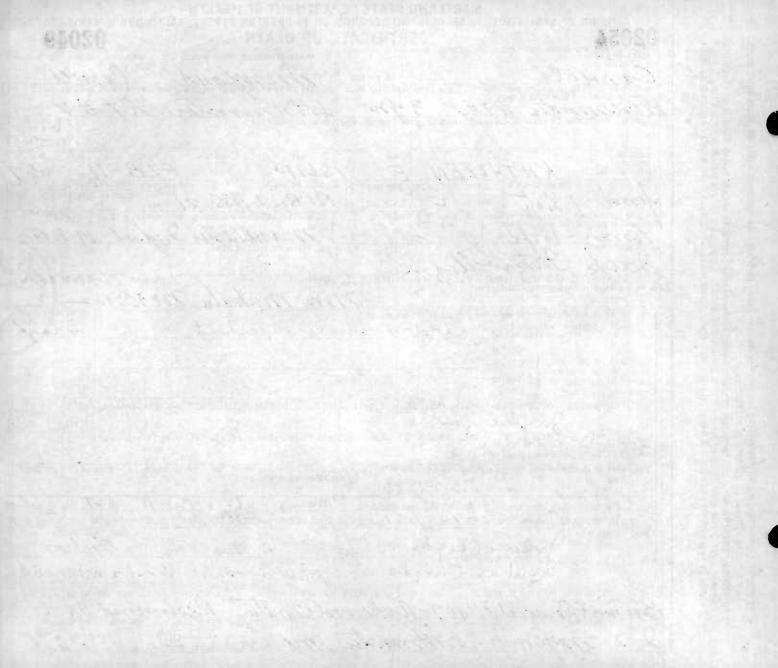
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	E DF DEATH			1, weg			IDENCE (Vhere decease			sidence before	admission)
	Carro	011		MARYL	IND	a. STATE/	rvla	Бо	b. cou	ltimo	ore	1
W	rite RURAL and g	outside corporate (ive nearest town)	limits,	c. LENGTH OF STAY		c. CITY OR TOV	VN (If outs					rest town)
d. N	inksbur	OR INSTITUTION	(if not In h.	ospital, give street add	troco)	d. STREET ADO	wson			0.	3-2	ESIDENCE
1			(ii not in n	ospital, give street aut	11 (22)			-			ON ON	A FARM?
	sandy Mi					1720					YES	
	ASED	First		Middle		Last	4.	DATE	Mon	th	Day	Year
	or print)	Anna		Grason		Hill		DEATH	2			967
5. SEX	6. C		. MARRIED	NEVER MARRIED		B. DATE OF BIRT		1.0	GE (In years st birthday)	IF UNDER 1	YEAR IF UNI	-
F			MIDOMED			Oct.12,	188	3 8:	3 yrs.	Wolfuls	Days Hou	is inthi.
during me	AL OCCUPATION (Gost of working life	ive kind of work do e, even If retired)	ne 10b. K	IND OF BUSINESS OR		11. BIRTHPLAC	CE (County	& State, or	foreign countr	y) 12. CI	TIZEN OF WI UNTRY?	IAT
	nemaker	,		No og ini		Balto	. Co	. Md			JSA	
13. FAT	HER'S NAME					14. MOTHER'S						
tW	illiam (rason				Anne	S.	P. Ch	ew			
15. WAS	DECEASED EVER I	NU.S. ARMED FORC	ES? 16.	SOCIAL SECURITY NO.	17.	INFORMANT			Addre	ss Roi	ite #	>
No.		give war or dates of se	ervice)		Mm	s. Ridge	A] W 1	T.O	a Fir			
		[Enter only one c	ause per II	Ine for (a), (b), and (c).		D. MANG	OL,y	1. 110	C 1 11.	INSUA	INTERVAL	
	PART I. DEATH V	AS CAUSED BY:	D11"	Lmonary ed					70.93		ONSET AN	D DEATH
	4221 IMM	IEDIATE CAUSE (a))(Linorial y ec	rems	4					16 1	irs.
Cond	litions, If any, v	DUE TO	Arte	riosclero	tic	2 0 77 7	Diana					
	rise to imme	diate (222001010	1010	- O.V. I	DISE	ise			year	es —
	e (a), stating)									
	rlying cause last	. /		ITING TO DEATH DUT NO			IN AL BLACK	-5-00117171	044 0 144 744 14		119. WAS	AUTODOV
E FAR	II. UTHER SIGNIF	ICANI CUNDITIONS	SCOMIKIBO	ITING TO DEATH BUT NO	IRELA	TED TO THE TERMI	INAL DISEA	SECUNDITI	IONGIVENIN	(PART 1(a)	PERF	AUTOPSY ORMED?
5								9.06			YES	NO Z
OR C	ACCIDENT WAS USENITHER, NOTIFY W	INDERLYING CAUSE OF DEATH IEDICAL EXAMINES	20b. [DESCRIBE HOW INJURY	occui	RRED. (Enter nati	ure of inju	ry in Part i	or Part II	of Item 18.)		
MEDICAL 20c.	TIME OF INJURY	Month, Day, Yea	ar 20d. II	NJURY OCCURRED 20	e. PLAC	E OF INJURY (Ho	me, farm,	20f. (City	y or town)	(Cour	ity)	(State)
E E	Hour a.m.		While	Not While	factor	y, street, office bl	dg., etc.)					
	p.m.	19	at work		7/4		- 1	757	-7 28	10 6	Ø	(- \ l1
2.	1. I certify that	d alive on F	al) attende	ed the deceased fro			,		_		that (I)	
22a	SIGNATURE	1 alive on	00 . L.	1901, an	tnat	death occurred		_M, from	the causes		e date stat TE SIGNED	ed above.
1	mart	- 80 - 1.0				ATTENDING PHYS.	MED.		STAFF	2-28		
22c.	PHYSICIAN'S	or conser			M.D.	PHYS. 22d. ADDRES	SS DIRE	CTOR	PHYS.	2-2-0		
	NAME (Type)	artin E	. Str	obel, M.D	•	1 0		st.Re	ister	stown	, Md.	
23a. BUI	RIAL, CREMATION MOVAL (Specify)	, 23b. DATE THE	EREOF	23c. NAME OF CEM	ETERY	OR CREMATORY	12	3d. LOCAT	ION (City, t	own or coul	nty)	(State)
	1al DIRECTOR	2-2-6	7	Prospect	: H:			Tows			Me	
				ADDRESS		25a.				men II Di	SIGNATURE	
H.W.	Jenkins	& Sons	Co.	1905 York	Rd	• DAT	MAR :	1 19	67 /	Client	A June	pa.
				balto.,Md								



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02053 CERTIFICATE OF DEATH death. The law requires that the death certificate be executed within 24 haurs after death and campletely filled in by the funeral remave carban papers. Pages 1 and in any event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Reside b. COUNTY Carroll o. COUNTY Carroll o. STATE Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Rural Taneytown Rural Tanevtown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Crouse Mill Road Enroute to Hospital YES NO X NAME OF Middle 4. DATE First Lost Month Dov Year DECEASED Charles 167 Hopkins 17 Howard February (Type or print) DEATH 1 YEAR IF UNDER 24 HRS. S. SEX AGE (In years IF UNDER 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED Months birthdoy) Doys Hours Male White Nov. 13, 1899 WIDOWED DIVORCED 1Do. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT lease during most of working life, even if retired)
Pharmacist Pharmacy COUNTRY? Baltimore City. Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Harry M. Hopkins Bertha Murray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address the attendir (Yes, no, or unknown) (If yes give wor or dotes of service permit g 212-07-8220A Mrs. Linda G. Hopkins Taneytown, Md. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REMOTED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? YES NO far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED (County) foctory, street, office blda., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram - 19 61 , 1967, that (N) (we) last 1967, and that death accurred at 9:337M, from causes and on the date stated above saw the deceased alive an 326 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Ambler Thompson Taneytown, Maryland directar, shauld 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) 2/21/67 Lutheran Cemetery Taneytown, Carroll, A REGISTRAR'S SIGNATURE Maryland 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR **ADDRESS** VR A15 (4) DATEB 20 M 1/66 John H. Skiles, C.O. Fuss & Son, Taneytown, Md.

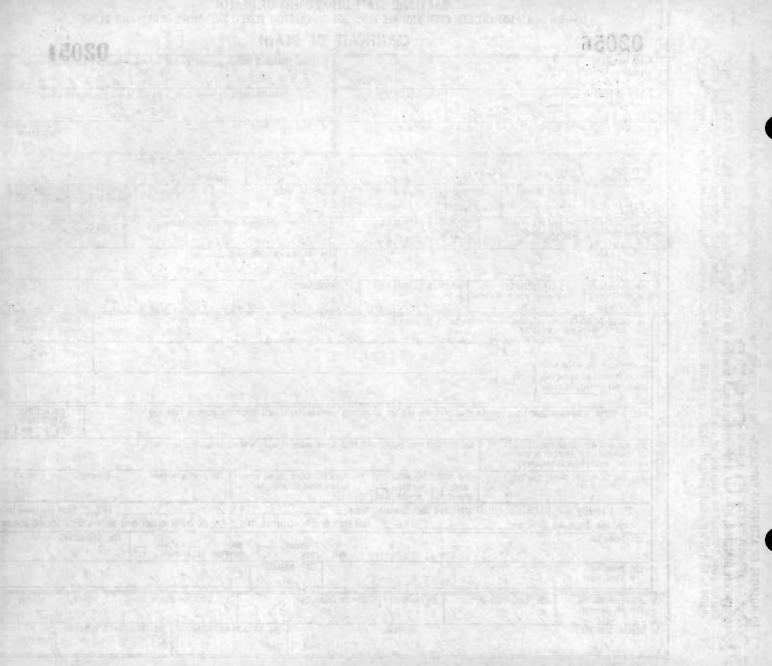


11	1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY	ZI ANID
7	- =0-1		02054 CERTIFICATE OF DEATH	149
	death.	1	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Resident a. COUNTY	ce before admission)
	24 hours after death. filled in by the funeral napers. Pages, 1 and 2 n 72 hours after death.		Carriel Co - MARYLAND Transland Carri	U
35	in by the Pages in ours after		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) THIS STAY IN 15 C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THIS STAY IN 15	(IVE nearest town)
	24 hou filled in 72 hou		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
			D. MANE OF	YES NO
	executed within 24 hours after and completely filled in by the 1 remove carbon papers. Pages 1 n any event, within 72 hours after	l'°	B. NAME OF First Middle Last 4. DATE Month Da OF DECEASED (Type or print) RATHLEFON F ISLIP DEATH FFB 11	1967
	com ove ove	5.	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR Months Days	R IF UNDER 24 HRS.
		11	DI. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZET	
	e be (ease lease and in	dj	wring most of working life, even if retired) INDUSTRY Manual Property of the country of the coun	XY?
	ficate by physici pleas	1	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	0 0/
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	requires that the death certificate be ding physician. been signed by the attending physiciar the burial-transit permit. There plasse or to burial, cremation, or removal, and in	0	(If yes give war or dates of service)	
	the de		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	ERVAL BETWEEN
	cian. cian. ed by trans		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebroranular secular 2 3 3 1X	+ days
	es the		Conditions, If any, which (b)	
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	The or a cate r use ealth	SATI	In fluenza	PERFORMED?
	ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. ECTOR: After this certificate has been signed by a should be detached for use as the burial-trans with the State Dept. of Health prior to burial, crem	CERTIFICATION	2Da. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	NG PHYS by the P fter this be detac state Dep	MEDICAL	2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED LOCAL PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work at wo	(State)
	ATTENDING retained by CTOR: Afte should be vith the Sta	2	21. I certify that (1) (this hospital) attended the deceased from Mar 3, 1962, to Fet 11, 1967, to	that (I) (we) last
	OR ATTENDI be retained URECTOR: A ge 3 should		saw the deceased alive on 1967, and that death occurred at 25PM, from the causes and on the da 22a. SIGNATURE 22b. DATE S	te stated above.
	AL OR nay be IL DIRE page 3 filed w		M.D. ATTENDING MED. STAFF WILL	67
	TO HOSPITAL OR ATTENDING F Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be should be filed with the State	1	22c. PHYSICIAN'S NAME (Type) Walius Chepko 85KW6 rean St Wastmingt	erlyd
	Page Page O FUI direct		3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	(State)
			24. FUNERAL DIRECTOR ADDRESS 25a. RED'D BY REGISTRAR 25b. REGISTRAR'S SIG	
	VR A15 (4)		2.2- myers &-, botheriste, motore FEB 14 1967 gelievele	Judge
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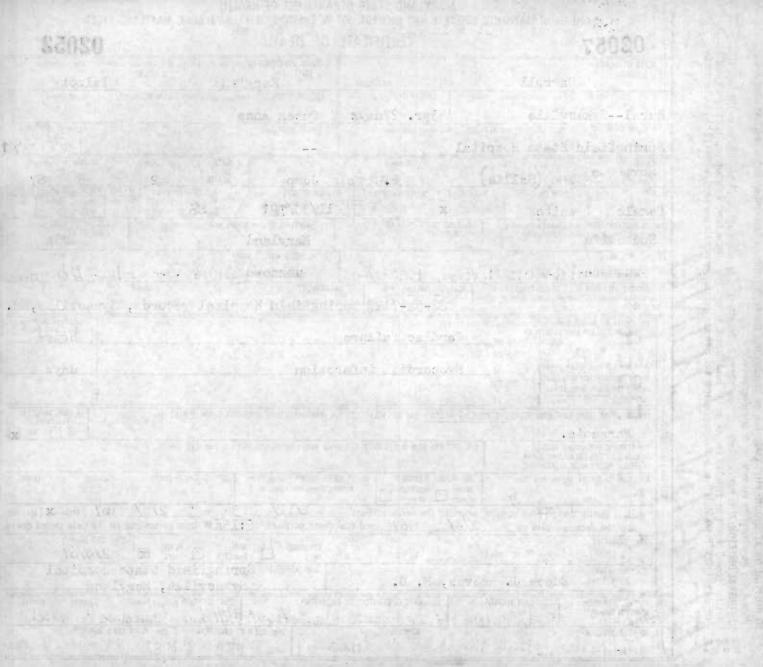


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 executed within 24 hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY rbon papers. Pages 1 a within 72 hours after d MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) has been signed by the attending physician and completely filled in a sthe burial-transit permit. Then please remove carbon papers. Figure to burial, cremation, or removal, and in any event within 72 hours lanches ter d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? NO YES NAME OF Day Year 3. Middle 4. DATE Month Last DECEASEO 0F DEATH 196 (Type or print) OWN AGE (In years | IF UNOER 1 YEAR | IF UNOER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF 9. 7. MARRIEO TINEVER MARRIED last birthday) Months Days Hours WIDOWED yrs. 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done | 11. BIRTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY that the death certificate, FATHER'S NAME MOTHER'S MAIOEN NAME 13. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 3 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. 2 Karn IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) WAS AUTOPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use PERFORMEO? TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for use should be filed with the State Dept. of Health NO F YES [20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) (State) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Oay, Year factory, street, office bldg., etc.) Hour a.m. MEDI Not While at work p.m. 19 at work Kthis hospital attended the deceased from and that death occurred at 2:3. M, from the causes and on the date stated above. saw the deceased alive 22b. DATE SIGNED 22a. SIGNATURE MED. STAFF ATTENDING M. O. PHYS. DIRECTOR PHYS. O HOSPITAL PHYSICIAN'S 22d. ADDRESS 22C. director, p NAME (Type) (State) **OATE THEREOF** NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23c. BURIAL, CREMATION, 23b. REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE 25a. FUNERAL DIRECTOR Charles VR A15 (4) DATE 20M 1/65

AND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02057 law requires that the death certificate be executed within 24 haurs after death and physicion and campletely filled in by the funeral on please remave carbon papers. Panes I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Talbot. b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pag. hin 72 haurs o Rural-Sykesville 27davs Queen Anne d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO Y Wit 3. NAME OF Middle 4. DATE Lost Month Dov Year DECEASED (Type or print) SARA BARTON 1967 Jump DEATH SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED birthdoy) Months Dovs Hours Min 11/30/78 WIDOWED X female white DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME unknown FRANCIS unknown the attending passit permit. The 15. WAS DECEASED EVER IN ILS. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 6 220+5/4-1/129 Springfield Hospital records, Sykesville, Md. IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit g cremat PART I. DEATH WAS CAUSED BY ONSET AND DEATH Cardiac failure IMMEDIATE CAUSE (o) nours DUE TO Conditions, if onv. which gove Myocardial infarction davs rise to immediate couse (a). DUF TO stoting the underlying couse be retained by the haspital or attending has been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Paranoia. NO TO FUNERAL DIRECTOR: After this certificate for 20o ACCIDENT WAS LINDERLYING TO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 2/8/ . 167 , that (# (we) last 21. I certify that (15 (this haspital) attended the deceased fram. 19 34 ta shauld 1967 . and that death accurred a5:15a M, fram causes and an the date stated above 2/8/ saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** 2/8/67 53 M.D. DIRECTOR PHYS PHYS e filed director, page TO HOSPITAL Page 4 may b 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Edmee J. Reeves. M. D. NAME (Type) Sykesville, Maryland shauld 23o. BURIAL, EREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAE (Specify) ISBORO Md FREENMOUNT BURIA FUNERAL DIRECTOR 2So. REL'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Misuley Jude 20 M 1/66 DATE



DIVISION OF STATISTICAL RESEARCH A 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, and the c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO E completely 3. NAME OF Middle 4. DATE Day Last Month Yeer DECEASED OF (Type or print) DEATH 19 and cor 890 AGE (In years | IF UNDER 1-YEAR 5. SEX IF UNDER 24 HRS. 6. COLOR B. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Days Months Hours WIDOWED DIVORCED USUAL OCCUPATION (Give kind of work physician 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM à 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN icate has been signed by ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gava rise to immadiata cause (a), stating the underlying PART IF, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1 19. WAS AUTOPSY CERTIFICATION PERFORMED? 0 NO P 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part If of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Whife Not While Hour a.m. at work at work to 2 saw the deceased alive on.... SIGNATURE 22b. DATE ATTENDING STAFF SIGNED DIRECTOR PHYS. PHYS. FUNERAL page Hampstead, Md. 22c. PHYSICIAN'S M. C. Porterfield NAME (Type) 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) Md. REMOVAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATURE REGISTRAR'S SIGNATURE Home Knmpstend A15 Funeral

PARTMENT OF HEALTH

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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	02060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02055
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY CARROLL MARYIAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY CARROLL MARYIAND D. COUNTY CARROLL
ent ent	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARROLL C. LENGTH OF STAY IN 1b Write RURAL and give nearest town) CARROLL C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
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o the 5 after after	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADORESS e. IS RESIDENCE ON A FARM?
lelay is to a solution of the	S6 JOHN ST. YES□ NO Z
any de 2, and PM3. The 3	3. NAME OF DECEASED (Type or print) LIGIX MAY LINTON Last 4. DATE Month Day Year. OF DEATH 2 - 6 - 1967
s 1, 2 srm P rum P with ithin	5. SEX 6. COLOR OR PACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min.
eath. Pages h for d 2 v	PEMALE WHITE WIOWED OIVORCED MARCH 29/895 7/ yrs.
after death. If a Give Pages 1, ong with form any event within any event within	during most of working life, even if retired) INDUSTRY COUNTRY?
8. Gong long any	DOMESTIC — FREDERICK MD U.S. U. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
Tall and	LOUIS BILINTON LIZZIE POOLE
office office File	15. WAS OECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address
within pencil in miner's permit.	- 218-54-2450 JANE IBEX, ADDRESS
d with pen mine per per rem	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN QUISET AND DEATH
ild be executed "pending" in "pending" in Medical Exam is burial-transit cremation, or in cremation, or in the cremation in the crematical interpretation in the crematical	IMMEDIATE CAUSE (a) Concurry Montposes (accord) Sudden
execution ding lical lical altra ation	Conditions, If any, which \ (a)
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iffication of the tipe of tipe of the tipe of	YES NO YES 20a. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
riting riting rded to	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH.
AL EXAMINER: This certificate should be executed within 24 hours after certificate, writing the word "pending" in pencil in item 18, should be forwarded to the Chief Medical Examiner's Office alon rifles. To should be used as a burial-transit permit. File pages designated agent, prior to burial, cremation, or removal, and in an	ZDc. TIME OF INJURY Month, Oay, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State) 2Df. (City or town) 2D
tific be be	
EXAMINE certifice certification be certification by the certification of	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner
the the cross desi	CHIEF MEDICAL EXAMINER
MEDICAL ecute the Page 4 s or your f or jurect	ACTUAL SIGNATURE SIGNED M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
UTY MEDICAL SECULE OF. Page ed for you EERAL DIRE	EXAMINER'S DEPUTY MEDICAL EXAMINER & & Cassall
O DEPUTY MEDI please execute director. Page retained for yo o FUNERAL DIR of Health or it.	NAME (Type) AND SIGNIFICATION (City, town or county)
of Hea	BEMOVAL (Specify) 2/8/67 CARROLL CO. HOME CEM. RURAL WESTMINSTERMD
	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME 350D 4-64	J. E. Myers, & Westminder, MyoATE FEB 9 1967 Schanley Judge
330D 4-04	

* MARKERNE CARROLL CARRELL 18 YRS WESTMINSTER WESTERNINSTER 56 JOHN 57. 56 JOHN ST TEMPLE WHITE MARCH 29/895 71 4-50. FREDERICK MD POMESTIC FORIS BYTHALL LIZZIE FROLE 314.442 218-54-2450 JANE IBEK, ADDRESS

BURIAL 2/8/67 CORROLL CO. HOME CEM RUGAL, HESTMINSTERMS

PRESTON STREET, BALTIMORE 1, MA 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution Residence before edmission) e. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN If outside corporate limits, write RURAL end give neerest town) write RURAL end give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give freet eddress) . IS RESIDENCE ON A FARM? YES NO completely 3. NAME OF 4. DATE Middle Month Dev Yeer DECEASED OF (Type or print) DEATH carbon-5. SEX 9. AGE (In years | IF UNDER I YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED and last birthday) Months Hours WIDOWED > 10a. USUAL OCCUPATION (Give kind of work (County & State. 12. CITIZEN OF WHAT COUNTRY? or foreign country) done during most of working life, Even if retired) House 13. FATHER'S NAME Hemler 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or detes of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if env. which geve rise to immediate cause DUE TO (e), steting the underlying CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): 19. WAS AUTOPSY PERFORMED? NO 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Pert II of item_18-) OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Hour a.m Not While et work at work 21. I certify that (I) (this hospital) attended the deceased from law 12-... that (1) (we) last saw the deceased alive on Jelzu M.M. from the causes and on the date stated above. , and that death occurred at 22e. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS DIRECTOR PHYS. M.D. 22c. PHYSICIAN 22d. ADDRESS 23d. LOCATION (City, town or 23e. BURTAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Slete) REMOVAL (Specify) Pines ChrchhCCemetery Adams Co. Straban FUNERAL DIRECTOR'S SIGNATURE 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **ADDRESS** VR A15 (4) 15M 7-62 DATE

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 9 02062 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence be 1. PLACE OF DEATH o. COUNTY Maryland Carroll Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) 20 years Tanevtown Tanevtown. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO W. Baltimore Street W. Baltimore Street 3. NAME OF Middle DATE Year DECEASEO Naylor, Sr Wilbur George February (Type or print) IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** Male White Sept. 9, 1901 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) U.S.A. during most of working life, even if retired)
Farmer **LNDUSTRY** Farming Frederick Co., Maryland 13. FATHER'S NAME Maude Estelle Stull George C. Naylor 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Mrs. Ruth Naylor, W. Balto. St., No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE to Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse WAS AUTOP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 2Dc. TIME OF INJURY Month, Doy, Year DIRECTOR: After this foctory, street, office bldg., etc.) Not While 21. I certify that (1) (this haspital) attended the deceased fram Hanz wer ablinated but Vallage Level (1976), of saw the deceased glive an Feb. 1 1967, and that death accurred at 11101MM, fram causes and an the date stated above saw the deceased alive an Fel 22o. SIGNATURE DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) HOMPSON 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, REMOVAL (Specify) Keysville, CarrollCe., Keysville Cemetery 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAY DIRECTOR Taneytown, Md. John H. SkilesDATE Fuss & Son

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institutions Residence before edmission) a. COUNTY e. STATE b. COUNT arro MARYLAND by the b. CITY OR TOWN (if outside/corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If sufside corporete limits, write RURAL end sive neerest town) wifte RURAL end give nearest town) papers. Pages 1 and 72 hours after of nes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RESIDENCE ON A FARM? YES NO NAME OF Middle 4. DATE Month Yeer DECEASED OF (Type or print) DEATH 19 6. COLOR OR RACE 7. MAKRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 9. last birthday) and Months Deys Hours DIVORCED WIDOWER 196. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY country 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) ause 13. FATHER'S NAME attending Q. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. | 17. Address (Yes, no, or unkown) | (If yes give wer or dates of service) physician. 18. CAUSE OF DEATH [Enter only one cause per line for (e) /(b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20e. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (County) (Stete) Month, Dev. Yeer 20f. (City or town) factory, street, office bldg., etc. While Not While Hour a.m. et work st work , and that death occurred at 1) MM, from the causes and on the date stated above ...19.6 saw the deceased alive on. 22b. DATE 22e. SIGNATURE MED. STAFF SIGNED DIRECTOR PHYS. FUNERAL 22d. ADDRESS 22c. PHYSTCIAN CAME (Type) ector, filled 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town 238. BURIAL, CREMATION, 236. DATE THEREOF 23d. REMOVAL (Specify) 0 5 2 11/1/11 25e REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4)

RTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 02064 certificate be executed within 24 haurs after death. and completely filled in by the funeral semave carban papers. Pages I and semante within 72 hours affecteat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland o. COUNTY Carroll County Carroll MARYLAND b. CITY OR TOWN (If autside carporate limits. c. LENGTH OF STAY IN 1b c, CITY OR TOWN (If outside comporate limits, write RURAL and give negrest tawn) Svke's VIIIe giv Marvland 9mons. 29 days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS 3220 Carlisle ON A FARM? Springfield State Hospital HOSDI/tall/1ES NOX NAME OF Middle First 4. DATE Manth Last Day Year DECEASED 19 67 Pirie Mav February Louise Type or print) DEATH 1 YEAR S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER IF UNDER 24 HRS. NEVER MARRIED 7. MARRIED log pirthdoy) 7-31-78 Months Dovs Hours White WIDOWED DIVORCED Female 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) **Beautician** 11, BIRTHPLACE (County & State, ar fareign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT please INDUSTRY COUNTRYS A Maryland 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME removal, Then Isabel McCov Henry J. Pirie Address Sykeswille and WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. The law requires that the death, the attendir (Yes, no, or unknown) (If yes give war ar dates af service) permit. 0 Hospital Records. 216-05-1215 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO Canditians, if any, which gave rise to immediate couse (a), psychotic reaction DUF TO stoting the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X YES for 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) af detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While at wark at wark 21. I certify that (I) (this hospital) attended the deceased from 4-7-66 19 66 to 2-5-197 , that (I) (we) lost and that death accurred aB:15A M, from causes and on the dote stated abave saw the deceased alive on 2-11-1967 22b. DATE SIGNED 22a SIGNATURE STAFF ATTENDING X 2-5-67 M.D. PHYS. DIRECTOR PHYS. be filed 22d ADDRESS 22c PHYSICIAN'S NAME (Type) Dr. Casal directar, should be 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, (County) REMOVAL (Spacify) Baltimore, Maryland 2/9/1967 Loudon Park Cemetery 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Ocharles 20 M 1/66 DATE FFR

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death	funeral and 2 r death.		1.	PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residen a. STATE b. COUNTY	ce before admission)
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requires that the death	d by transit			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branche-Malerman	NSET AND DEATH
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ATTENDING	After After IId be cone State		2		that (1) (we) last
	TOR Show			saw the deceased alive on 2/26 1967, and that death occurred at 10 M, from the causes and on the da	ate stated above.
OR A	DIRECTOR: A sign of should led with the			22a. SIGNATURE 22b. DATE STAFF 2b. DATE STAFF	IGNED 7
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02067 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. the attending physician and completely filled in by the funeral sit permit. Then please remove carban papers. Pages 1 and 3 nation, or removal, and in any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Baltimore City b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Sykesville 43yrs.lmo.13dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS 12 S. Greene St. Springfield State Hospital YES 🗔 NO X 3 NAME OF Middle 4. DATE First Month Dov Year DECEASED 18 67 FEBRUARY 19 (Type or print) WILLIAM NMN RADESKY DEATH IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH e remove in any eve NEVER MARRIED Jost birthdoy) Months Doys Hours Male White April, 1894 WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Maryland Employee Factory Hand

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Israel Radesky Esther Cohen IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 220-54-6659 Records, Springfield State Hospital IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p burial, crematic ONSET AND DEATH Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Schizophrenic reaction, hebephrenic type NO TO YES be retained by the hospital or for 20o. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour a.m. Not While ot work pe 21. I certify that (1) (this haspital) attended the deceased fram 1-5-24 , 19___, that (1) (we) last should saw the deceased alive an 2-18-67 19 and that death accurred at M. fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING X 2-20-67 CAMASO. DIRECTOR M.D. Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Agustin del Campo, M. D. Sykesville, Maryland director, should b 23o. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify)
Burial Baltimore, Maryland 2/22/67 Rodse Zedek 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D 8Y REGISTRAR VR A15 (4) 20 M 1/66 Sol Levinson & Bros. Inc., 6010 Reist., Rd. DATEFEB VCharley

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02068 CERTIFICATE OF DEATH death. law requires that the deoth certificate be executed within 24 hours after deoth physician and completely filled in by the funeral en please remove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY a. COUNTY o. STATE Carroll Maryland Baltimore City MARYLAND vithin 72 hours after c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b. Sykesville Baltimore 18 dvs. d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? 2926 Harford Road Springfield State Hospital YES T NO X NAME OF DECEASED Middle Last 4. DATE Day Year ROSE (NMN) REHLING IF UNDER 1 YEAR FEBRUARY (Type or print) DEATH AGE (In years IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED rthday) Months Doys Hours 11-25-1880 Female White WIDOWED X DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT ond in COUNTRY? during most of working life, even if retired) INDUSTRY U.S.A Housewife Maryland
14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME offending phys or removol John Meyer Mary Unclebach 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address permit. (Yes, na, or unknown) (If yes give war or dotes of service) Unk. Records, Springfield State Hospital 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-transit ONSET AND DEATH Carcinoma of the left lung with metastasis to IMMEDIATE CAUSE (a) signed by be retained by the hospitol or ottending physician. the liver DUF TO Canditians, if ony, which gave Acute embolism, right lung hours rise ta immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been os the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES X NO PHYSICIAN: for 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) (City or town) (County) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg., etc.) Nat While OR ATTENDING 19 at wark pe 2-22-67, 19___, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 2-1-67 should and that death accurred a5:05 RM fram causes and an the date stated above. saw the deceased alive on 2-22-67 19 22b. DATE SIGNED -22a. SIGNATURE ATTENDING PHYS. STAFF PHYS. 2-23-67 director, page 3 should be filed v DIRECTOR Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) Antonius Glahn. M. D. Sykesville, Maryland 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (Caunty) (Stote) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Baltimore Md. Western 20-1067 ADDRESS 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 North Ave., Strong Milane G. Howard

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY Filed b. COUNTY MARYLAND Carrol Maryland Howard b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Years Ellicott City Union Bridge d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE OR INSTITUTION ON A FARM? Torton Nursing Home YES NO TO NAME OF First Middle 4. DATE Lost Month Year Day DECEASED Ernest (Type or print) Abby Ridgelv DEATH Feb. 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH Months Male White DIVORCED T WIDOWED TY Oct. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Farming Farmer Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Edward Ridgely Catherine Burns 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Mrs. Forrest Peddicord Marriottsville 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate DUE TO caese (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO TO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, farm, Doy. Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc. Hour a.m. While Not while of work at work p. m. 21. I certify that I attended the deceased from that I last saw the deceased AM, fram the causes and an the date stated above. and that death occurred at_ ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL shauld PHYSICIAN'S obertson NAME (Type) 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 15M 9/SS

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CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) a. COUNTY b. COUNTY by the and 2 death. Carroll Maryland MARYLAND Carroll b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give nearest town) 5-Middleburg Rural Taneytown 4 vears papers. Pages 72 hours after d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Brookfield Manor Nursing Home completely 3. NAME OF 4. DATE Month Dev Yeer Last DECEASED OF (Type or print) DEATH 1967 within Gertie Ridinger Mav February and col 7. MARRIED NEVER MARRIED 3 B. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR 5. SEX 6. COLOR OR RACE 9. IF UNDER 24 HRS. last birthday) Months Days Female White Sept.11.1887 WIDOWED DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) None Carroll Co. Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME affending John Ridinger Clara Shoemaker 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) No None Vern H. Ridinger RFD. Taneytown. Md. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).) INTERVAL BETWEEN ONSET AND DEATH Thero Scheros PART I. DEATH WAS CAUSED BY: signed IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (e), steting the underlying the cause last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) | 19. WAS AUTOPSY CERTIFICATION certificat as PERFORMED? 5 use prior syn drone NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert t or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY 20d, INJURY OCCURRED | 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) Month, Day, Year factory, street, office bldg., etc.) While Not While Hour e.m. et work el work 0 19, that (I) (we) last to ... saw the deceased alive causes and on the date stated above. 22b. DATE 228. SIGNATURE SIGNED ATTENDING . STAFF PHYS. DIRECTOR leath. Page 4 22d. ADDRESS 22c. PHYS/CIAN'S NAME (Type) Union Bridge, Md. J.H. Caricofe 230. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) D. g. g REMOVAL (Specify) Burial United Brethern Cemetery Taneytown. Maryland 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61 C.O. Fuss & Son, Taneytown, Md. DATE

hours after

executed

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death certificate

requires that the

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17.5	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH
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	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. QTY OR TOWN (If outside corporate limits, write RURAL end give neerest town)
	write RURAL and give neerest town)
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDEN
p	ON A FARI
	Long View Nevering Home 11-13 00 YES NO
	3. NAME OF First Middle. Last 4. DATE Month Dey Year OF OF
30	(Type or print) MATGATOT HICE RICY DEATH THE 1967
1	5. SEX 6. COLOP OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTY 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR
	Lamelo Willate WIDOWED DIVORCED Aveil 20 1887 79 yrs. Months Days Hours Min
Sec.	100. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11) BIRTHPLACE (County & Stete, or foreign country) 12. CITIZEN OF WHAT COUNT
	done during most of working life, even if retired)
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	11 time to alline
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 14. SOCIAL SECURITY NO. 17. INFORMANT. Address: A Contract of the
10	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (Iffyes give were rates of service)
	No 186-0.5-360 ray 15 cary Salestment Md
	18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Concluse Variables accordent Education
	DUE TO 1
	Conditions, if any, which \ (b) generally of arterior levous 5 mg
	geve rise to immadiate cause
190	(a), steting the underlying cause lest.
	Z PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOP
7	PERFORMED
The said	YES NO
	20e. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
	UIF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State Hour a.m. While Not While fectory, street, office bldg., etc.)
14	Hour a.m. P.m. 19 ef work ef work
	21. I certify that (1) (this hospital) attended the deceased from 12/2/2/ to 2/1/1. to 2/1/1. that (1) (we)
	saw the deceased alive on 21.7, and that death occurred at 3 My from the causes and on the date slated about
	22b. DA
	ATTENDING MED. STAFF SIG
	M.J. 11000 (C)
1	22c. PHYSICIAN'S NAME (Type) 1/1+ F 1 110 22d. ADDRESS
	I I I I and MIN ANCHUS INTO
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) (State)
	Burial Feb. 20. 1967 Fairfield Union Fairfield, Adams Co. Pa.
;	24 PUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
	Clarence E. Wilson Emmitsburg, Md. DATFEB 21 1967 Milanles Judge
	Clarence E. Wilson

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n= 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	02072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02067
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
(M)	a. COUNTY Carroll MARYLAND MARYLAND a. STATE b. COUNTY Carroll Carroll
Ssary, e.s. funeral e 5 may be Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
fun fun may artm artm	Woodbine Life Woodbine
Dep affe	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
nd 3 to Page State D hours af	YES NOTE
de, 3. P	3. NAME OF First Middle Last 4. DATE Month Day Yeer DECEASED OF
PM3.	(Type or print) /= KNON MEKINLEY (Type ON) DEATH Neprent 23, 1967
form P form P form within	last birthday) Months Days Hours Min.
Page h for	
er dea sive Pa sive Pa si si Pa si si Pa si si Pa si si Pa si Pa si si p si si si p si si p si si s	during most of working life, even if retired) INDUSTRY COUNTRY?
ours afte n 18. Gi e along pages 1 in any	Laborer Carroll Co., Md. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ours m 1 e a pag	George W. Rippeon Mary Catherin e Foreman
24 ho liter Office File and	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, pr. unkown) (If yes pive war or dates of service)
hin Sill ir r's nit.	Yes WW 1 227-20-1019 Manley Reid Rippeon Same As #2
Adminer. This certificate should be executed within 24 hours after death. If any death the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and should be forwarded to the Chief Medical Examiner's Office along with form PM3. r files. CIOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Sidesignated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent, prior to burial, cremation, or removal, and in any event within 72 houdesignated agent.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
Exal Sit or	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corcerly throughout Could Short
xecu ding' cal trar tion,	The dollars of any which a DUE TO
be e pend Medi urial emal	Conditions, If eny, which gave rise to immediate (b)
outd "d "ief I	cause (a), stating the DUE TO underlying cause last. (c)
icate should be executed the word "pending" in the Chief Medical Exaused as a burial-transit to burial, cremation, or	(V) WAS AUTODOV
the the use to b	YES NO X
ing d to	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? YES NO YES NO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? YES NO CAUSE OF DEATH.
writ writ arde ould t, pu	
R: This certificate, writing forwarded to 3 should be agent, prior	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.) While Not While at work at work
INER Inficon De De D	
AAMINE A should be Ir files. CTOR: Page designated	21. Teerthy that I took charge of the foliation described describe
AA the cession of the	death resulted from: Natural causes A. Accident L., Suicide L., Homicide L., Undetermined manner L.
MA. ecute the Page 4 or your L DIRECT or its d	ACTUAL SIGNATURE Deille M.D. ASSISTANT MEDICAL EXAMINER (22. DATE SIGNED
execute Page I for you IAL DIRE	DEPUTY MEDICAL EXAMINER
PUT. se ettor. ned ned salth	NAME (Type) / W. Glenn Speicher address start, but beward or gold the start with
TO DEPUTY M.L. AA please execute the ce director. Page 4 shoul retained for your files. TO FUNERAL DIRECTOR: of Health or its design	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF THE STATE 23d. LOCATION (City, town or county)
1 1 1	Burial" 2/27/1967 Morgan Chanel Carroll Co. Md 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME	C. M. Waltz Box 241 Sykesville, Md. DATE FEB 28 1967 Icharles Quese
3500 4-64	The state of the s

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

LINE	10	04013			CEKIIF	ICAIL	OF DEATH			112	ARS.	
funera 1 and er death	Ī.	PLACE OF DEATH o. COUNTY	Carroll		MARY	IAND	2. USUAL RESIDENCE (o. STATE Md		ased lived, if institu b. COU	tion: Residence NTY	befare admi	
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hin 72 haurs	1	Finks bu	autside corparate limi give nearest tawn)					Finks	burg	E GII UN	06-	/
7		d. NAME OF HOSPITA	L OR INSTITUTION (If n	not in haspital,	give street oddress)		d. STREET ADDRESS				e. IS RE	SIDENCE FARM?
00		R.D.	. 1					R.D			YES	
	3.	NAME OF DECEASED		irst	Middle		Last	4. DATE OF				Year
=)		(Type or print)	Anita	A.	Robert			DEATH				9 67
		SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED		B. DATE OF BIRTH		 AGE (In years last birthdoy) 	Months 1	Days Haur	DER 24 HRS.
	E	emale	White	WIDOWED	DIVORCED		May 7, 189	1	Of yrs.			
	100	USUAL OCCUPATION	(Give kind of work dane		IND OF BUSINESS OR IDUSTRY		11. BIRTHPLACE (County	& State, ar f		12. CITIZ	ZEN OF WHAT	
	001	ng most of working I House	ewife	"	DOSIKI		Carroll	Co.	Md.	100	S.A.	
	13.	FATHER'S NAME				21,000	14. MOTHER'S MAIDEN	NAME				
		Henry	Lessner				Eliz	abeth	Mille	er		
	IS.	WAS DECEASED EVE	R IN U.S. ARMED FORCES	of convice!	SOCIAL SECURITY NO.		NFORMANT	7-18-	Addr	ess		1800
5	100	NO NO	(If yes give wor or dates	of service)	12-05-7388	B	John H. R	obert	s Finl	ksburg,	Md.	
crematian, or remaval, and i		1B. CAUSE OF DE	ATH (Enter only one co	iuse per line foi	(a), (b), and (c)		1.		n -	#	INTERVAL	
		PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE	(a) Lee	ite N	Ma	Callea	d	KSarc	in	ONSET ANI	DEATH
		420	1	E TO	1	7 1	-1 - 1)		1.//		7	
		Conditions, if ony,		(b) LLC	ellosel	ela	he He	ext	Whisea	1	5.42	2
		rise to immediate		E TO					Y			
		last.)	(c)				1				
. 0	Z	PART II. OTHER SIG	GNIFICANT CONDITIONS	CONTRIBUTING	TO DEATH BUT NOT REL	ATED TO 1	THE TERMINAL DISEASE CO	NDITION GIV	/EN IN PART 1(o)		19. WAS A PERFO	UTOPSY RMED?
2	ATIO							will be			YES	NO 🔽
	CERTIFICATION	20a. ACCIDENT WAS	UNDERLYING CAUSE OF DEATH	20b. D	SCRIBE HOW INJURY OF	CCURRED.	(Enter nature of injury in	Part I or Pa	ort II of item 1B.)			
			MEDICAL EXAMINER)									
340	MEDICAL	20c. TIME OF INJU	RY Month, Day, Year	2Dd. I While	NJURY OCCURRED		CE OF INJURY (Hame, farr ary, street, affice bldg., etc.		(City or town)	(Coun	ty)	(Stote)
	W	p.m	1. 19	at wa	k 🔲 at work 🔲	- 1	\"					
5					ded the deceased	from_	jul .	1965.	to Jeb 2	196	thot ((we) las
			ceased alive on_	yan	1967,	and the	death occurred of	42	M, from couses			ted obove
<u> </u>		22a. SIGNATURE	11.4	116	14		ATTENDING -	MED.	STAFF -	22b. DAT	E SIGNED	
-		AV	A VI	Con y	n.v	J.M		DIRECTOR	PHYS. L		1	
		22c. PHYSICIAN'S NAME (Type)		Uigh	A MD.		22d. ADDRESS	ens	naun	me	<u>d</u>	
should	23	. BURIAL, CREMATIO	N, 23b. DATE TI	HEREOF/	23c. NAME OF CEME	TERY OR	CREMATORY	23d. l	LOCATION (City or To	own) (County)	(State)
		Buria (Specify)	3/1/	67	Immunea	1 C	emetery		lancheste:		roll,	Md.
n I	2	. FUNERAL DIRECTO		KI PALL	ADDRESS	1600		D BY REGIS		ECISTRAR'S SIG	MATURIA	del
15	1	ipton - 1	Eline Fune	ral Hon	e Hampstea	d. M	d. DATE N	IAR 1	1967	1	0	a

Tipton - Eline Funeral Home Hampstead, Md.

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< 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1,	MADVI AND
H = 24	02074 CERTIFICATE OF DEATH	2060
hours after death. d in by the funeral rs. Pages 1 and 2 thours after death.	PLACE OF DEATH a. COUNTY A. MARYLAND A. STATE B. COUNTY A. MARYLAND A. STATE B. COUNTY A. COUNTY A. COUNTY A. COUNTY A. STATE B. COUNTY A. COUNT	Residence before admission) ARPOLL
ours af in by the Pages iours al	b. CITY OR TOWN (if outside corporate limits, write RUR!) Write RURAL and give nearest town) RURAL, WESTMINSTER 86 YRS, RURAL, WESTMINSTER	AL and give nearest town) PLA4061
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rted within 24 hours after completely filled in by the f ve carbon papers. Pages 1 event, within 72 hours after	3. NAME OF First Middle Last 4. DATE Month OF	Day Year
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDE Months	10, 1967 ER 1 YEAR FUNDER 24 HRS. Days Hours Min.
be exectician and ase remo	10a. USUAL OCCUPATION (Give kind of work done of the d	CITIZEN OF WHAT
	RURAL MAIL CARRIER RETIRED CARROLL CO. MD	4-5.9.
certifica rding ph Then emoval	St. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
death after semi-	(Yes, no, or unkown) (If yes give war or dates of service) G. EDWIN ROBERTSON 134 SAN	mainst.
hat the cician. cian. ed by the	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCAR DIAL INFARCTION	ONSET AND DEATH
ires that i physician signed k burial-trat burial, cre	Conditions, If any, which DUE TO ARTERIOSCLEROSIS	10 YRS
aw requir ttending p has been as the b prior to b	gave rise to immediate cause (a), stating the underlying cause last.	
4: The law isl or attential or attentificate has for use as Health prior		19. WAS AUTOPSY PERFORMED?
Cert cert hed t. of	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) DIABETES MELLICITUS 5-6 YEARS 20a. ACCIDENT WAS UNDERLYING DEATH OF CONTRIBUTING DEADER OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 1 (IF EITHER, NOTIFY MEDICAL EXAMINER)	
JING PHYSIC d by the hos After this ce d be detache s State Dept.	Zoc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (City or town) 20f. (City or town) 20	ounty) (State)
	21. I certify that (I) (this hospital) attended the deceased from TAM, 1963, to FEB. 10, 1963, saw the deceased alive on FEB. 10 1967, and that death occurred at 7.30 AM, from the causes and on	the date stated above.
L OR ATTENI y be retaine DIRECTOR: age 3 shoul	William 7. Stewart, M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 1	DATE SIGNED 2 /10/67
TO HOSPITAL OR Page 4 may be TO FUNERAL DIRE director, page 3 should be filed v	22c. PHYSICIAN'S NAME (Type) NILLIAM L. STEWART 19 RIDGE RD, WESTMINST	ELMO.
TO HO Pag Pag dire shou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or of REMOVAL (Specify) 2/13/67 WESTMINSTER GENERAL WESTMINSTER	PMD
VR A15 (4)	24. FUNERAL DIRECTOR ADDRESS 25a. RRC'D BY REGISTRAR 25b. REGIST	inverse Judge
15M 4-64		

\$2.00 m CONTRACTOR OF THE SECOND SERVICE OF THE SECOND SECO JULY 1227 7#22 AURY 722 THE WALL STATE OF THE STATE OF KIRH CHILLIANTE KETHED CHERTILLA IND 44 S. C. MONTH THOUGHT RACKE HOOK Eximit amount tomoring the - TSHUSTE - LAMOUR SIPAL " 2/13/67 DETENDATED BEETH MISTORIES OF

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02075 CERTIFICATE OF DEATH signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remave carbon papers. Pages I and 2 burial, cremation, ar remaval, and it any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Maryland Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) MARYLAND C. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carparate limits. write RURAL and give nearest town) Sykesville Sparrows Point 22vrs.7mos.12dvs. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2916 Salisbury Ave. Springfield State Hospital YES NO TO 3. NAME OF Middle 4. DATE First Last Manth Day Year DECEASED ERNEST ROSE WILHO FEBRUARY 67 19 Type or print DEATH IF UNDER 1 YEAR S. SEX 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Months Days Haurs Male White WIDOWED 1-11:-05 10g, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired) COUNTRY? INDUSTRY Machinist Pennsylvania
14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Axel Rose (last name unk. Rosa 1S. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, ar unknown) ((If yes give war ar dates af service) 17 INFORMANT 16. SOCIAL SECURITY NO. 167-03-2781 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Acute peritonitis Page 4 may be retained by the hospital or attending physician. **DUE TO** Conditions, if ony, which gove (b) Perforated duodenal ulcer Days rise to immediate cause (a). Months & DUE TO has been s ise as the b th priar tab stating the underlying couse Gangrene of right leg due to arteriosclerosis Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS with CNS syphilis, meningoencephalitic, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES TO NO this certificate PHYSICIAN: for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or tawn) (County) (State) Hour o.m. foctory, street, office bldg., etc.) Nat While ATTENDING ot work O FUNERAL DIRECTOR: After at wark 21. I certify that (1) (this haspital) attended the deceased fram. 19___, that (1) (we) last director, page 3 shauld shauld be filed with the 2-9-67 and that death accurred at: M. Fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED 2-9-67 DIRECTOR M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Octavio A. Ruiz, M. D. NAME (Type) Sykasville, Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATOR' 23d. LOCATION (City or Town) BURIAL, CREMATION (County) (State) REMOVAL (Specify) SUKESU reedon emete 25q-REC'D, BY REGISTRAR 25b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

14 " STANDERSON OF DELEVATION OF STANDARD . Other thought fire NES Linux Dank Frank Frank De page 18 Control of the Branch State of the S 193-1-10 minutes and the second of the Betariora . Write D. D. C. C. C. Start L. C. Start L. C. Start C. Start C. Start C. Start C. C. Start C.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02076 CERTIFICATE OF DEATH filled in by the funeral no papers. Pages 1 and 2 within 72 hours after death. deoth. low requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. County Carroll a. COUNTY a. STATE Carroll MARYLAND arvland c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) 2 weeks Finksburg Westminster d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Carroll County General Hospital Niner Rd . YES X NO NAME OF Middle physician ond completely f en pleose remove corbon First Last 4. DATE Month Day Year DECEASED OF DEATH 2 1067 Charles John Ross (Type or print) S. SEX 6. COLOR OR RACE IF UNDER 24 HRS 7. MARRIED IXI NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR Jast birthday) Days Haurs Oct. White Male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast of warking life, even it retired)
St. Car Conduct Bal to COUNTRY? A. Transit Baltimore Co.. Md. Conductor 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending phy buriol-transit permit. Then John B. Ross Marguerite Burns 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Niner Rd., (Yes, na. ar unknawn) (If yes give war ar dates of service) 216-12-0861 Mrs. Sylvia T. Ross nksburg. No 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN SNSET AND DEATH CIRCULATORY FAILURE IMMEDIATE CAUSE (a) physician. DHE TO ARTERIOSCLEROTIC HEART DISEASE-Canditians, if any, which gave rise ta immediate cause (a). DHE-TO stating the underlying cause os the has been WEEKS DECOMPENSATED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? SROWCHO PIVEUMONIA Page 4 may be retained by the hospital or O FUNERAL DIRECTOR: After this certificate YES NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur a.m. Nat While factory, street, affice bldg., etc.) at wark 21. I certify that (I) (this haspital) attended the deceased fram_ . 1967 to . 3/23 , 1967, that (I) (we) last should 2/33 1967, and that death accurred at 1/3 M, fram causes and an the date stated above. saw the deceased alive an_ 220 SJENATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR poge 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS director, p 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City ar Tawn) 23a. BURIAL, CREMATION, (Caunty) REMOVAL (Specify) 2/25/67 Finksburg, Carroll, Evergreen Mem. Gardens 24. FUNERAL DIRECTOR **ADDRESS** 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) DATFEB Owings Mills, Md. Charles Varias

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d 1(N/1)	MARYLAND STATE DEPARTMENT OF HEALTH OR DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAI	OVIAND
0	02077 CERTIFICATE OF DEATH	19
death.	1 PLACE OF DEATH	lence before admission
e fu	a. COUNTY CARROLL MARYLAND a. STATE Md. b. COUNTY CAR	roll
afte y th iges aft	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and	
24 hours after filled in by the apers. Pages 1 n 72 hours after	KUTAL- Woodbine YEARS KUTAL- Woodbine	06-1
led led	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
y fill pap	Route 97 Route 97	YES NO NO
be executed within 24 hours after cian and completely filled in by the iase remove carbon papers. Pages 1 nd in any event, within 72 hours after	3. NAME OF DECEASED (Type or print) TAMES HARRIS SANNER, SR. DEATH Feb. 10	Day Year 1967
uted w compl ove can	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 1894 9. AGE (In years IF UNDER 1Y Months Da	
execute and co remove	MARIE WIDOWED DIVORCED JULY 14. 1895 72 yrs.	
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	Office Manage R Drugs Mary and U.S.	A ,
tifica ng pl hen nova	George R. SAMPER LAURA MACKEY	
ath cert attending irmit. Th n, or rem	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT	
ires that the death certificate be execuphysician. It is gred by the attending physician and burial-transit permit. Then please remoburial, cremation, or removal, and in any	(Yes, no, or unkown) (If yes give war or dates of service) MR. HATTIS SATINER, JR Woodbins	e. Md.
the direction	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	NTERVAL BETWEEN ONSET AND DEATH
at the lan. d by ransi crem	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Coronary Artery	few min.
res that physician signed i surial-trai	4801 DUE TO	
uire g ph en s en s bui	Conditions, If any, which gave rise to Immediate (b) Chronic Hypertensive Cardiovascular	15:
requir nding p been the bi	tundarlying saves test	15+ yrs.
s law requires that tattending physician. be has been signed be as the burial-tran		19. WAS AUTOPSY PERFORMED?
The cate	(YES NO
ATTENDING PHYSICIAN: The law requires that the death certificate retained by the hospital or attending physician. IECTOR: After this certificate has been signed by the attending physis should be detached for use as the burial-transit permit. Then ple with the State Dept. of Health prior to burial, cremation, or removal, a	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
HYS he h this letac	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. White Factory, street, office bldg., etc.)) (State)
of by the draw of	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County factory, street, office bldg., etc.)	
ATTENDING retained by CTOR. After should be should the Stat	21. I certify that (I) (this hospital) attended the deceased from 1965, to 10/Feb/679	, that (I) (we) last
ATTE retai CTO sho sho ith i	saw the deceased alive on 10/Feb/67 19 , and that death occurred at 1 PM, from the causes and on the	date stated above
DOR Doe of w	M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	Grantes
TAL may AL I page e fille	22c. PHYSICIAN'S NAME (Type)	
HOSPITAL Page 4 may FUNERAL I director, pag		yland
TO HOSPITAL OR ATTEN Page 4 may be retain TO FUNERAL DIRECTOR: director, page 3 shoul should be filed with th	23a BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county	
	BUTIAL DIRECTOR AND ADDRESS 125a. REC'D BY REGISTRAR 25b. REGISTRAR'S S	IGNATURE
VR AI5 (4)	Harry W. Haight Sykesville, Md. DATEFEB 16 1967 Schanle	· Verso
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02078 CERTIFICATE OF DEATH be executed within 24 hours after death. death. ng physician and completely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) o. COUNTY o. SIME Maryland b. COUNTY Baltimore County Carroll oon popers. Poges 1 within 72 hours ofter MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside corparate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest town)
Sykesville Randallstown Lmos. 13dvs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 3808 Courtleigh Drive YES NO THE 3. NAME OF First Middle 4. DATE Last Dov Year DECEASED (Type or print) AUGUST JOHN. SCHMITT 19 67 DEATH FEBRUARY SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years NEVER MARRIED DATE OF BIRTH Manths birthday) Davs Haurs 8-8-1897 Male White ond in ony Sep DIVORCED 10a, USUAL OCCUPATION (Give kind of work dane KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? certificote Keti) Fireman 10. Dept. Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Frederick Schmitt Katherine Schmidt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address low requires that the death affend (Yes, no, or unknown) ((If yes give wor or dotes of service permit. 10 218-26-3625 Yes - Army, 1916-1919 Records. Springfield State Hospital buriol, crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) the buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY signed by 1 IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Canditians, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse os the Years WAS AUTOPSY II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) you consider the condition of the c PERFORMED? without qualifying phrase NO or 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH jo (IF EITHER, NOTIFY MEDICAL EXAMINER be detoched Stote Dept. of 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City ar tawn) (County) (Stote) factory, street, office bldg., etc.) Hour a.m. Not While at work 21. I certify that (I) (this hospital) attended the deceased fram 9-23-66 19____, that (I) (we) last director, page 3 should should be filed with the saw the deceased alive an2-6-67 and that death occurred at M. fram causes and on the date stated above. 220. SIGNATURE 22b. DATE SIGNED OR 2-6-67 M.D. DIRECTOR PHYS 22d. ADDRESSSpringfield State Hospital 22c. PHYSICIAN NAME (Type) H Sykesville. Maryland Connor. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23a. BURIAL, CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) emeteru 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02073 CERTIFICATE OF DEATH executed within 24 hours after death deoth pletely filled in by the funeral corban papers. Pages 1 and ent, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY g STATE Maryland Allegany Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Cumberland 7mos 21dvs Sykasville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled 16 N. Lee Street Springfield State Hospital NO K YES 3. NAME OF Middle 4. DATE Month Year DECEASED ANNE GERTRUDE SHERRED 67 FEBRUARY 19 (Type or print) DEATH 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED X pledse remove NEVER MARRIED last birthdoy) Hours Dovs in ony 10-12-1891 WIDOWED Fema.1e White DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT The law requires that the death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? and West Virginia Housewife U.S.A the offending physicisit permit. Then ple 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, John Ross Webb Elizabeth (last name unk.) 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 20 214-05-5869A Records, Springfield State Hospital cremotion, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY CHISET AND DEATH Carcinoma of esophagus TO FUNERAL DIRECTOR: After this certificate has been signed by IMMEDIATE CAUSE (o) Page 4 moy be retained by the hospital or ottending physicion. DUE TO buriol, Acute peritonitis due to superior mesenteric Conditions, if ony, which gove Days rise to immediate couse (a), artery thrombosis stoting the underlying couse prior to far use os the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CBS assoc. with settle brain disease, without qualifying phrase YES X NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached for OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) State ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram 6-16-66 3 should I and that death accurred ap: 15 2-7-6 M. fram causes and an the date stated above. saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING 2-7-67 M.D. director, page should be filed 22° PHYSICIAN'S Springfield State Hospital NAME (Type) Agustin del Campo. Sykesyille, Maryland 23o. BURIAL CREMATION 23b. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town (County) REMOVAL (Specific) ADDRESS 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY ARROLL b. CITY OR TOWN (if outside corporate limits,	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institute as STATE bs. COUNTY c. CITY OR TOWN (if outside corporate limits, write RUR,			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) AND BRIDGE d. NAME OF HOSPITAL OR INSTITUTION (if not in	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RUR) UNION BRIDGE d. STREET ADDRESS	AL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in	n hospital, give street address)	d. STREET ADDRESS RRAHNWAY	e. IS RESIDEN ON A FAR		

		CARROLL MARYLAND	a. STATE MAR	VIANID 6. COUNTY	CARRALL
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN	(If outside corporate limits, write I	RURAL and give nearest town)
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10		d. NAME OF HOSPITAL OR INSTITUTION (il not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
00	2	NAME OF First Middle	BROAL		YES NO
1		NAME OF DECEASED (Type or print) RIITH I AVINIA SNY	N E P	4. DATE Month OF DEATH	Day Year
,		SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.	DATE OF BIRTH	9. AGE (In years	F UNDER 1 YEAR IF UNDER 24 HRS.
		F WIDOWED N DIVORCED S	EPT 19-1	1899 19 yrs.	Months Deys Hours Min.
		USUAL OCCUPATION (Give kind of work ne during most of working life, even if refired)	11. BIRTHPLACE (Cou	nty & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY
3		HOUSENIFE OWN HOME	MARYL	AND	USA
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN	NAME	
8	1E	FOSTER WAREHIME	VINNIE	BENEDICT	H H C C C ARTHE
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN 18, no, or unkown) (If yes give war or deles of service)	VFORMANT	Address	TOLORE MA
	_	18. CAUSE OF DEATH (Enter only one cause per line lorgia), (b), and (c).	OLIVIA !	HAY UNION B	PIDG-L- III
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	meal I	Thensis	ONSET AND DEATH
d		17/X DUE TO O	1		
		Conditions, if eny, which \ (b) Radeation The	rapy for	La caremon	a of the
		gave rise to immediate cause (a), stating the underlying	ND		1950
8		cause last.			1759
0	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT	RELATED TO THE TERMI	INAL DISEASE CONDITION GIVE	PERFORMED?
	FICA	208. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED.	(Enter nature of injury in	Part Lor Part II of item 18)	YES NO
	CERTIFI	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Line) include of infair, in	Ten y of ten if of hem to.,	
	CAL		CE OF INJURY (Home, far ry, street, office bldg., etc		(County) (State)
	MEDI	Hour a.m. While Not While set work to et work	ry, siredi, diffice blug., en		
	19	21. I certify that (I) (this hospital) attended the deceased from	1957	19 10 2/8/6	7, 19, that (I) (we) la
9		saw the deceased alive on 2 7 47 19 and that co	death occurred a	A, M, from the causes ar	nd on the date stated above
		220. SIGNATURE		MED. STAFF	22b. DATE SIGNE
		22c. PHYSICIAN'S	PHYS.	DIRECTOR PHYS.	70101
1		NAME (PYDE) J H CARICOFE	UNION	BRIDGE	MP
		B. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O	R CREMATORY	23d. LOCATION (City, town	or county) (State)
		BURIAL 2/11/67 MT VIEW		4NION BRI	DGE MD
0	24	FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2	/_ 25a. RE	C'D BY REGISTRAR 256. REGI	STRAR'S SIGNATURE
A		NA MULICIEN SOME UNION DILA	ge DATE	FEB 1 0 11967	y marley Judge

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02081 CERTIFICATE OF DEATH Spuo requires that the death certificate be executed within 24 hours after death the attending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) I. PLACE OF DEATH o. COUNTY b. COUNTY laryland Carroll Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) Brunswick d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Carroll Co. General Hospital Rosemont YES NOX 3. NAME OF First Middle 4. DATE Month Lost Doy Year DECEASED 1967 2 SHAW WALTZ TITITE (Type or print) DEATH SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE NEVER MARRIED 7. MARRIED Jast birthdoy) Months Doys Hours X WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life even if retired)
HOUSEWIIE COUNTRY? A. INDUSTRY Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remova George Shaw Myra Forrest 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16 SOCIAL SECURITY NO (If yes give wor or dates of service) Westminkster Md. 216-46-0524Mrs. Murial Kable no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-tronsit p burial, crematic PART I. DEATH WAS CAUSED BY: ONSET AND DEATH PARCINOMA OF RIGHT IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove WITH METASTASES VERRS STANT rise to immediate couse (o), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate hos been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) for use NO T YES T EBRAI ASCULAR INSUFFICIENCY the hospitol or 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Hour o.m. Not While ot work . 1967, that (1) (we) lost 21. I certify that (I) (this hospital) attended the deceased from_ 2/6 . 1967 . to 1967, and that death accurred at 954 M, fram causes and an the date stated above. saw the deceased alive on 220. SIGNATURE 22b. DATESIGNED ATTENDING M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 230. BURIAL, CREMATION REMOVAL 1900 OF THE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) Mar (Stote) Cemeterv 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Brunswick Md. VR A15 (4) 120 M 1/66 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02083 death. requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a. STATE b COUNTY Carroll Balto. MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Westminster van papers. Pag within 72 hours Reisterstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Carroll County General Hospt. Old Hanover Road YES NO IN 3. NAME OF Middle First 4. DATE Month Day Year DECEASED S. Welsh 2 18 Marion 1969 (Type or print) DEATH S SEX 6. COLOR OR RACE 7. MARRIED Sc. B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED birthday) Months Doys Haurs Female White Sept. 22, 1895 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Balto. City 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME remay Edward E. Lewis Ella J. Rhoten 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 220-48-5226 Mr. A. Earl Welsh Reisterstown. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH PIAPHRAGMATIC + IMMEDIATE CAUSE (a) signed by MJOCARDIAL INFARCTION HOURS Conditions, if ony, which gave rise to immediate cause (a). DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the priar ta last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use YES NO the haspital or for 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office blda., etc.) Nat While 21. I certify that (1) (this haspital) attended the deceased fram. 1967 to 19____, that (I) (we) last FO HOSPITAL OR ATTENE Page 4 may be retained pluods and that death accurred at 6 44 2//8 saw the deceased alive an M, fram causes and an the date stated above. 220 SUGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed a M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Finksburg, Md. Evergreen Memorial 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Reisterstown, Md. . Eline & Sons Cherrelan

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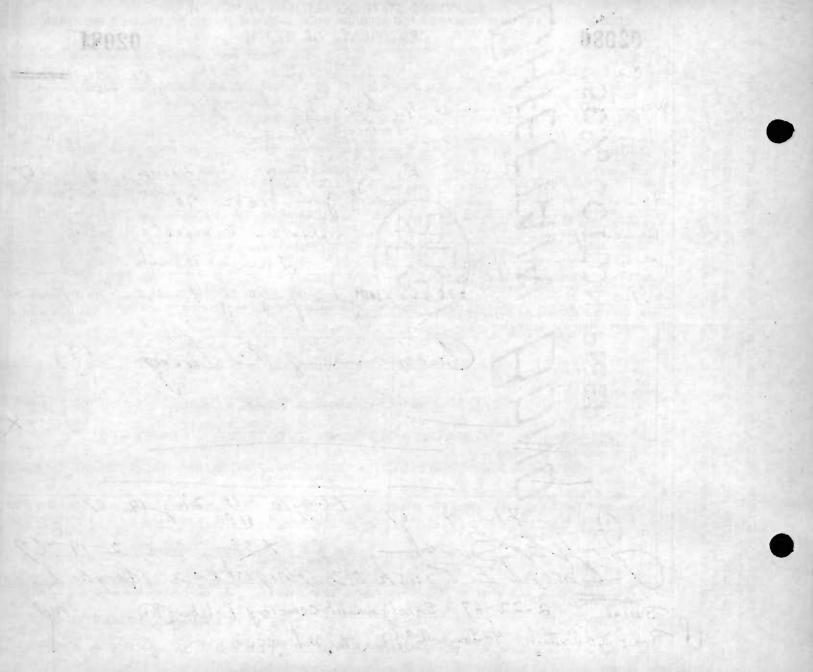
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02085 CERTIFICATE OF DEATH attending physician and campletely filled in by the funeral permit. Then please remove carbon papers. Pages 1 and 2 permit. requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DONETON est mins les d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 60 YES NO X NAME OF Middle Month Doy Year DECEASED (Type or print) Wallace DEATH 196/ 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 7. MARRIED X NEVER MARRIED lost birthdoy) Months WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR RTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 1 Sood Ward 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO signed Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending as the TO FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health NO X YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldq., etc.) Not While ot work ot work 21. I certify that (I) (this haspital) attended the deceased fram 2-25 1, to 8 0 27 19 6 7, and that death accurred at 900 M, from causes and on the date stated above saw the deceased alive and should 22o. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR 2-27-66 M.D. PHYS director, page shauld be filed 22c. PHYSICIAN'S 22d. ADDRESS Karl M. Green, M.D. Westminster, Maryland NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) REMOVAL Specify b. Hosp. 2-27-67 Westminster, Car., Carroll Co. Gen. Hosp. 2So. REC'D BY REGISTRAR Glenn R. Fisher, Administrator Carroll County General Hospital VR A15 (4) 1967 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY Pages 1 a a. STATE b. COUNTY MARYLAND b. CITY DR TDWN (if outside corporate limits, c. LENGTH DF STAY IN 1b c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) and completely filled in by emove carbon papers. Pag any event, within 72 hours 24 hours 128 Nmani mil d. NAME OF HDSPITAL DR INSTITUTION (if not in hospital, gife street agricess) e. IS RESIDENCE d. STREET ADDRESS DN A FARM? YES PND within 3. NAMEOF Middle DATE Year Last Month Day DECEASED DF DEATH E (Type or print) 19 ALUALY executed AGE (In years AF UNDER TYEAR IF UNDER 24 HRS. Last birthday) Months | Days | Hours | Min. SEX 6. CDLDR, DR RACE NEVER MARRIED DATE OF BIRTH 7. MARRIED WIDDWED DIVDRCED 10a. USUAL DCCUPATION (Give kind of work done | BIRTHPLACE (County & State, or foreign country) 10b. KIND DF BUSINESS DR 12. CITIZEN DF WHAT ician please in pe during most of working life, even if retired) INDUSTRY CDUNTRY? Houseke physi death certificate 13. FATHER'S NAME MDTHER'S MAIDEN NAME attending ph ermit. Then remova 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. INFDRMAN' Address transit permit. 17. (Yes, no, or unkown) | (If yes give war or dates of service) 220-26 the CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN The law requires that the -transit DNSET AND DEATH PART 1. DEATH WAS CAUSED BY: the hospital or attending physician. been signed the burial-transcript to burial, cre IMMEDIATE CAUSE (a) DUE TD Cenditions, If any, which (b) gave rise to immediate as the prior to DUE TD cause (a), stating the underlying cause last. (C) CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY use for use Health PERFORMED? certificate ND X PHYSICIAN: detached for 20a. ACCIDENT WAS UNDERLYING T 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLACE DF INJURY (Home, farm, 2Df. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While OR ATTENDING P While After at work at work T Februa 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the PM, from the causes and on the date stated above. saw the deceased alive on 2 and that death occurred at SIGNATURE DATE SIGNED 22a. 22b. page ATTENDING PHYS. M.D. DIRECTOR Page 4 may 1 PHYSICIANS FUNERAL 22c. 22d. ADDRESS director, p NAME (Dybe) 23a. BURIAL, GREMATION. 23b. DATE THERED 23d. LDCATION (City, town or county) (State) 23c. REMOVAL (Specify) 2 Cemeler ADDRES FUNERAL DIRECTOR REC'D BY REGISTRAR 1-25b. REGISTRAR'S SIGNATURE Lowwell and 1/65



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